Annual Report

1972

Assessment and Placement Service

of the Hamilton District Health Council

TABLE OF CONTENTS

APPENDIX

LIST OF TABLES

List of Tables Continued . . .

LIST OF GRAPHS

ACKNOWLEDGMENTS

Acknowledgment should be given to the contribution of the members of the Extended Care Committee and especially to Mr. Ronald Hatch the first Chairman, and to Dr. J. C. Allison who succeeded him during the period covered by this report for their helpful guidance and support.

An expression of appreciation is due also to Dr. Gary Anderson and Mr. Larry Chambers of the McMaster Department of Clinical Epidemiology & Biostatistics for most valuable assistance in data collection and handling.

ABSTRACT

This report of the Extended Care Committee to the Hamilton District Health Council gives the background information that led to the formation of the Assessment & Placement Service and a review of the work done in the first twelve months of its existence, that is from September 1, 1971 to August 31, 1972.

Summary of First Annual Report

Aims & Purposes of A.P.S.

WHO IS IT FOR?

People of any age who need long-term treatment, or special living facilities whether they are at home, in hospital or elsewhere.

WHAT DOES IT DO?

The A.P.S. works with family physicians and health teams in institutions or in the community to assess both medical and social problems in order to determine the amount of help required. Placement is recommended in accordance with this assessment.

WHAT FACILITIES ARE AVAILABLE?

Homes for the Aged, Nursing Homes, Chronic Hospitals, Lodging Homes, Adult Training Centres, Rehabilitation Centres, Home Care etc. are all considered by the A.P.S. in recommending the appropriate programs.

HOW MUCH DOES IT COST?

There is no charge for this service. It is funded by the Ministry of Health.

WHAT IS THE PURPOSE?

To ensure that no one is neglected or forgotten, and that no family or institution is taxed beyond its limits. By serving the entire community the A.P.S. will be able to collect accurate information about what is still needed in treatment or care programs.

WHO ARE THE STAFF? (Sept./71 - Aug./72)

A Medical Director, an Administrator, a Registered Nurse, a Social Worker, an Information Coordinator and a Secretary who are responsible to the Extended Care Committee of the Hamilton District Health Council.

Problems identified by A.P.S.
(in order of appearance in Annual Report)

1. Guidance in assessment is needed for health professionals to obtain a full picture of the problems of handicapped people.
2. Confused and disturbed behaviour needs to be well controlled before a patient is transferred from a hospital.
3. Social isolation was a common characteristic of applicants, the majority of whom were aged, 75% were single, separated, divorced or widowed, 28% had been living alone and 35% lacked anyone at home to assist in activities of daily living (dressing, feeding, washing, etc.)
4. 53 persons spoke only languages other than English which required special consideration in placement.
5. Various causes of confusional state need careful differentiation for appropriate management.
6. 86% of referred persons had impairments of memory or judgment and 91% had impairment in activities of daily living.
7. Of placements back into the community, a number were considered generally unsatisfactory by A.P.S. because of insufficient community support services, or because the applicant was not placed in the appropriate level of care due to his refusal or a disregard of A.P.S. recommendations.

8. Referrals to A.P.S. from general hospitals have constituted from approximately 60% to less than 30% of all discharges to extended care facilities made by them. This excludes one hospital which uses a definition of "extended care" very different from the others, and another hospital that up to now has made little use of A.P.S.
9. By the end of the first year of operation about half of all admissions to "chronic hospitals", Homes for the Aged and nursing homes were made through A.P.S.
10. There is a tendency for health professionals to focus on short term needs and goals for handicapped patients and clients without developing good long term plans.
11. Persons with terminal illnesses do not seem to receive sufficient emotional support and counselling.
12. Present attitudes seem to emphasize discharge from hospital as a goal for the patient rather than as a means to a goal. For the hospital early discharge is desirable as it releases a bed, but one must be certain that the patient's needs will be met elsewhere.
13. Inconsistent information in the A.P.S. form suggests health professionals have not communicated well and may not be working as a team.
14. Hospital staffs may refer patients when ready for discharge and then want speedy action, but this impairs adequate planning.
15. Plans for discharge and placement are often not incorporated in the treatment plan formulated when the patient is admitted.
16. Lack of understanding of the purposes of health facilities results in unreasonable demands being put on such organizations as chronic hospitals, nursing homes, Homes for the Aged, Home Care and psychiatric services, which in consequence may be misused.
17. Admission criteria for health institutions sometimes do not correspond to community health needs. Information to guide admission policies can be derived from the assessments of A.P.S.
18. Transfer of information between health institutions has in the past been insufficient in some cases to enable a recipient institution to judge if it can meet a patient's needs or not, or to guide the staff after the patient is accepted.
19. Placement without A.P.S. involvement enables some institutions to select lighter cases and prevents fair distribution of difficult ones.
20. The higher standards set by the Ministry of Health Extended Health Care benefit program has caused some nursing homes to close. The additional load of finding suitable placements fell upon A.P.S. and was successfully carried.
21. Although physiotherapy and related services are needed in nursing homes for specific treatments, prevention of over-use and the necessity to ensure optimal distribution of such services within a community may require their organization within a district program.
22. The Extended Health Care benefit eligibility is judged from a special government form. This form does not assess what the person needs but only the eligibility for that benefit. The A.P.S. form assesses the needs of the applicant and his potential.
23. The Extended Health care benefit form creates extra work if completed on persons not eligible due to their need of more or less than that level of nursing care. It should be completed after A.P.S. assessment has shown the level of care needed.
24. Nursing homes have lacked activation and recreation programs and new govern-

ment regulations now require them. Sufficient attention has not been given to the problems involved in terms of organization of programs, identification of existing available services, analysis of a resident's ability to participate, ways of motivating participation, and the types of programs appropriate to such residents and institutions. The A.P.S. sponsored study and workshop on Reactivation in Nursing Homes has identified these issues and some solutions.

25. There is a lack of supervised residential non-institutional accommodation for people who should not live alone but do not want to enter an institution and do not require actual care.
26. Follow-up of handicapped persons after treatment is sometimes provided by the treatment staff but this can be insufficient and also time consuming. Public health nurses working in different sectors of the community could be specifically trained to follow-up and report back.
27. Special programs for specific disability groups or age groups are needed that will coordinate all relevant services for the benefit of that group.
28. Greater attention should be focussed on the needs of the chronically disabled and handicapped. Increased efficiency and effectiveness of planning and programing is needed.

Action by A.P.S.

— developed an assessment form that (a) guides health professionals in obtaining a complete picture of a person's basic needs and attributes, (b) enables A.P.S. team to identify an appropriate program, (c) provides codable data for analysis as a basis for planning.

— identified existing treatment, recreation, education, and care programs appropriate to the needs of handicapped people.

— identified gaps in knowledge of health professionals and remedied these by providing information or suggesting information sources.

— promoted better communication among health professionals, and understanding of their functions.

— promoted coordination and cooperation between institutions in developing programs, sharing resources and exchanging information.

— aided in the transfer of patients between institutions or into the community to diminish the stress on the patient and to ensure he received appropriate care.

— studied the problems inherent in developing activation programs in nursing homes and organized a workshop to help them to develop such programs. Provided a resource book on activation and where to obtain further advice and help.

— initiated the development of a follow-up service by public health nurses for eventual use by any professional for all handicapped people.

— promoted the development of special programs for handicapped children, spinal cord injury people and others.

— identified a need for sheltered residential non-institutional accommodation and initiated its development and showed a lack of need for institutional residential accommodation for well aged.

— provided a source of knowledge for students from faculties of medicine, nursing, social work, physical-education and for visitors from Canada, the U.S.A., Britain and Australia.

— developed an abstracting coding form for purpose of statistical analysis.

— transcribed low level and high level data from Referral Form to coding form.

— used the following steps in handling data —
  — data key punched and verified.
  — data entered on computer; wrote a code sheet, and debugged code sheet and data cards.
  — analysis of data: listing of response distribution to all questions, two-way table analysis.
  — description in words of what these tables show.
  — compiled data in the 1971-72 Annual Report to provide a data base for further studies and to provide useful comparative measures of the performance of A.P.S. and of the various health programs in the region in the second year of operation of A.P.S.

Future developments

The assessment form is to be improved in the light of experience gained over the past year, a third draft will be given a trial of use and a printed format may then be produced.

The use of A.P.S. by practitioners and health institutions is expected to grow to complete utilization. In addition, growing public awareness of the service will lead to earlier referrals from the community and the possibility of identifying in detail the need of and planning for community services as an alternative to institutional care.

A plan is being formulated through A.P.S. and the Extended Care Committee for the development of auxiliary (foster) homes for those people who need sheltered accommodation without institutionalization.

A follow-up service is being planned through A.P.S. and the Extended Care Committee for people with on-going handicaps or disabilities to assist them in adjusting to the setting or program and to prevent or identify early any breakdown in function. Such a service may be provided by public health nurses after suitable instruction, with information feed-back going to A.P.S. and the responsible person or team.

Careful follow-up of people with already identified conditions which may relapse should result in better preventive and supportive programs, and in avoidance of the hasty emergency action that is sometimes required because a situation in the home or community has progressed too far.

Further expansion of Home Care programs may be possible, to provide on-going maintenance or repeated shorter interventions as needed to help the person remain at home. Services might be provided also to nursing care or other institutions to augment their own programs. These questions are being studied by the Extended Care Committee.

Activation programs for people confined to institutions or private homes will be developed by the cooperative efforts of all the long stay institutions, voluntary agencies and government services. Red Cross volunteers and other groups have visited people in institutions for some time. Following the A.P.S. Reactivation Workshop (see above), the occupational therapists of several local hospitals have set up short training programs for any staff member of a local nursing home. Other recommendations of the Workshop will be developed.

The educational component of A.P.S. function is vital to promote cooperative planning and a coordinated approach to community health needs. Although time

consuming, it does not seem possible to reduce this activity and each team member is accepting the responsibility to inform the health professionals and staffs of designated institutions with whom she relates regularly. Members of the Extended Care Committee also have a vital role in this area.

In summary, it may be seen that the A.P.S. has grown rapidly in the twelve months since its inception, and is becoming widely accepted. Its contribution in planning, information, coordination and service is already substantial but the potential for future development is still unfolding.

Assessment and Placement Service
of the
Committee on Extended Health Care
Hamilton District Health Council

FIRST ANNUAL REPORT — SEPTEMBER 1, 1971 — AUGUST 31, 1972

Chronic Diseases a Major Health Problem

Major achievements in improving the effectiveness of medical treatment and especially in improving public health by better sanitation and nutrition over the last 100 years has dramatically reduced mortality in children and young adults and resulted in the large numbers of mature adults alive today. As adults grow older, however, they may develop one or more chronic diseases such as vascular disease, disease of the neurological system, arthritis, cancer, diabetes mellitus and others. Such conditions may appear relatively early in life but are most prevalent among the elderly and account for a considerable amount of disability and handicap in late life. A few chronic physically disabling conditions may occur in early life, some of them due to genetically inherited factors, due to injury or infection with permanent residual defect, but the major disabling diseases of early adult life are behavioural and psychological.

Inability at our present state of knowledge, to prevent these conditions has thrown the emphasis onto early detection and treatment that aims to prevent further deterioration and where possible to restore lost function. Even such illnesses as myocardial infarction and stroke which come on abruptly and may require urgent care are based on underlying vascular disease, and have often been present for a number of years. The tremendous increase in medical technological knowledge and skill has produced refinements of diagnosis and management that may be life saving and enable many with these chronic diseases to regain full function and others to survive but with handicaps. The technological equipment and expertise to operate it has increased health costs greatly and their localization in general hospitals has altered the focus of hospitals from care and support to diagnosis and intensive care. Evaluation of effectiveness is based at least in part on the numbers of patients admitted and the brevity of the average length of stay. Thus even patients with obvious care needs are not expected to remain in high cost general hospital beds but either to be cared for by relatives or in a long stay institution of some sort. Another development over the last 100 years in Western culture has been the disappearance of the extended family of 3 generations living under one roof. This is related to urbanization, to increased wealth that allows each generation to live in their own homes, and to the concept that both men and women should be able to develop careers and interests without an absolute obligation to care for parents or grandparents disabled by disease. Although recent studies [1] show that a great deal of communication occurs between the elderly and their adult children, it is evident that living separately in small housing units makes it difficult to provide close

[1] Older People in Three Industrial Societies, Shanas, Townsend, et al. Atherton Press, New York, 1968.

supervision and care if disability occurs.

It is not surprising therefore to find that although people age 65 and over constitute 8.1% of the population of Canada, they stay longer than the average length of time in general hospitals and occupy a disproportionate number of beds.[2] Handicapped children can usually be managed by their parents until adulthood when their increased size and weight, and the increasing age of the parents, may make management in the home more difficult.

Modern psychological treatment methods, better understanding of family and community relationships and psychotherapeutic medications have made it possible to deal with most persons with behavioural problems in the physician's office, in psychiatric sections of general hospitals or with short-term admissions to the psychiatric hospital. Persons needing long term care for psychological problems are generally the severely mentally retarded, those with major personality and psycho-social problems, those who have been in a psychiatric institution for some years and have adjusted to it with loss of community and family contacts, and those elderly who have developed confusion and disturbed behaviour due to several types of brain damage. Because such people cannot respond in a major way to therapy, there is a reluctance to admit or continue accommodating them in psychiatric hospitals and various long term programs have been developed of which the "special care homes" organized by the Ministry of Health is one.

Population and Regional Health Services

The distribution of health care facilities varies somewhat in different areas of Ontario, and this report will deal with those in Hamilton, the neighbouring communities and the surrounding district. The City of Hamilton has a population of 309,173 (according to most recent Advance Bulletin of the 1971 census), and with the neighbouring cities and towns such as Burlington, Waterdown, Dundas, and Stoney Creek and the farming communities around the west end of Lake Ontario there is a total population of about approximately 600,000. (The census Metropolitan Area of Hamilton has a population of 498,523 according to the most recent Advance Bulletin of the 1971 Canadian Census). Hamilton is a major industrial city with large steel mills and many secondary industries. Settlement occurred over 100 years ago and there are many elderly people who grew up here. However, immigration from many parts of the world has brought in people with different language and cultural backgrounds. The provision of long term care is influenced by such backgrounds.

Hospital Services

Serving the area there are 5 acute treatment hospitals, 4 in Hamilton (Chedoke General and Children's Hospital, Hamilton General Hospital, Henderson General Hospital, St. Joseph's Hospital) and 1 in Burlington (Joseph Brant Memorial Hospital) totalling 2,533 beds (including 124 psychiatric beds) and giving a bed-population ratio of 4 per 1000. During the time that this report covers (September 1, 1971 - August 31, 1972) McMaster University Medical Centre Hospital had not yet opened. The cost per day for this level of care is approximately $70.00. The Hamilton Psychiatric Hospital has 6 wards with a total of 270 beds to which one can be admitted directly (including an alcoholic unit and an adolescent unit) and 8 wards of 520 beds to which one has to be transferred. The cost per day for a psychiatric hospital bed is approximately $35.00.

[2] "Illness and Health Care in Canada", Canadian Sickness Survey 1950-51.

There are two types of Rehabilitation Units designated by the Regulations of O.H.S.C., August, 1971: "Special" Rehabilitation: a severely disabled patient with complicated physical disability which may be accompanied by social and/or psychological complications and requiring rehabilitative team management in a designated Regional Special Rehabilitation Referral Unit. "General" Rehabilitation: a recovering (short or long term) patient, past the most acute or severe stage of illness but still requiring an organized programme of physical medicine and general rehabilitation in a hospital. The Chedoke-McMaster Centre has been designated as the Regional "Special" Rehabilitation Unit and has a capacity of 71 beds. One of the "General" Rehabilitation Units is attached to an acute treatment hospital (Henderson) and another is attached to a Chronic Hospital (Brow Infirmary) with a total capacity of 107 beds, or an overall total of 178 Rehabilitation beds (Special and General).

A Chronic Hospital is defined under The Public Hospitals Act, 1971, (ch 322, Section 1 (f) and Section 14 (3) : " 'hospital' means any institution, building or other premises or place established for the treatment of persons afflicted with or suffering from sickness, a disease or injury, or for the treatment of convalescent or chronically ill persons, that is approved under this Act as a public hospital." No Chronic Hospital "shall be required to admit as a patient a convalescent person or a person who is in need of active treatment, and no hospital for chronically ill persons . . . shall refuse to admit as a patient any chronically ill person so certified and referred to it from an active treatment hospital in accordance with the regulations". Two large chronic disease hospitals, a chronic care ward of one of the general hospitals, provide on-going medical care, skilled nursing, physiotherapy, occupational therapy, social casework and other services, as required, with a total bed capacity of 340. Two chronic care wards in another general hospital were not available during the period covered by this report. There are also two smaller institutions offering very heavy nursing care, but not the other services as mentioned, that are licenced to provide chronic care with 49 beds, giving a total of 389 beds. All patients in such accommodation are covered by the Ontario Hospital Insurance Program at a cost of approximately $30.00 per day.

Residential and Nursing Care Institutions

There are two types of institutions to which patients with needs for care or supervision may go: Nursing Homes or Homes for the Aged. The Nursing Homes are licenced by the provincial Ministry of Health if they meet certain standards of building safety, space, equipment and service. They are commercial enterprises, and vary in size from the small converted private house to the large specially constructed institution which may be part of a chain. According to The Nursing Homes Act, 1972 (ch. 11, section 1 (g)) "a 'nursing home' means any premises maintained and operated for persons requiring nursing care or in which such care is provided to two or more unrelated persons . . . ". "Nursing care" includes: "intermediate nursing care", which is defined in the Regulations as meaning "nursing and personal care given by or under the supervision of a registered nurse or registered nursing assistant under the direction of a physician to a resident for less than one and one-half hours per day"; and "extended care", which is defined in the same way as "intermediate care" except that it has a "minimum of one and a half hours per day" of care. The Ontario government introduced the Extended Health Care Benefit program in April 1972 which raised the standards to be met both in space and personnel and limited the amount that could be charged. The program allowed $12.50 per day to be charged for standard accommodation of which $9.00 per day would

be paid from government funds. Seventy-five per cent of the beds in the institution had to be allocated for insured persons and no nursing home licence could be obtained if such persons were not accepted.[3] Institutional nursing care cannot legally be provided outside a licenced facility.[4]

Eligibility for the Extended Care Benefit depends on the statement by the personal physician that the person requires between 1½ and 2½ hours of nursing care per day using a special form of the Ministry of Health. In addition the person must have been a resident in the province for 1 year and must have paid Health Insurance premiums. Recently, inspectors have been appointed in all regions to visit the nursing homes, and help them meet the new requirements. In the Hamilton district there are 29 licenced nursing homes with a total of 1295 beds. Of these beds, 75% or 971 are allocated for extended care and 25% or 324 are intermediate care beds.

The Homes for the Aged are in general sponsored and administrated by municipalities, counties or non-profit organizations. In this district there are 5 homes with a total of 1118 beds. According to The Homes for the Aged and Rest Homes Act, 1969, a Home for the Aged is set up under the Department of Social and Family Services and can accept three categories of patients: normal, special and bed care. According to Ch. 174, Section 13 (1) a,b,c,d of the Act, any person may be admitted to and maintained in a home for the aged:

> "(a) who is over the age of sixty years and incapable of supporting himself or unable to care properly for himself; (NORMAL CARE = 633 beds)
>
> (b) who is over the age of sixty years and mentally incompetent and who requires care, supervision and control for his protection, but who is not a mentally ill person or a mentally defective person within the meaning of The Mental Hospitals Act and who is not eligible for admission to an institution under the Act; (SPECIAL CARE = 177 beds)
>
> (c) who is over the age of sixty years and who requires bed care and general personal nursing services, but does not require care in a hospital (BED CARE = 308 beds)
>
> (d) who is under the age of sixty years and who because of special circumstances cannot be cared for adequately elsewhere, if his admission is approved by the Minister."

Although "special care" and "bed care" are primarily for residents who decline in health from "normal care", it is possible to obtain admission directly from the community if space allows it. The Homes for the Aged also accept people covered under the Extended Care program although no specific ratio of insured residents to non-insured has been decided as yet. On the average the Homes for the Aged have 55% of their residents covered by Extended Care (or a potential 615 beds). Foster homes have been developed under the auspices of a Home for the Aged in some areas but not yet in this district.

Within the "Homes for Special Care" program mentioned above in connection with the psychiatric hospital, there are two types of accommodation: supervision in a private home and nursing care in a licenced nursing home. There is a total of

[3] The Nursing Homes Act, 1972, Statutes of Ontario, 1972 Ch 11 and Ontario Regulation 196/72, May 1972, Queens Printer, clause a of subsection 2 of section 4, and section 18.

[4] Ibid., clause g of section 1 and section 18.

557 beds so utilized in this district. (The Homes for Special Care "district" is the catchment area for the Hamilton Psychiatric Hospital: the counties of Hamilton-Wentworth, Halton, Brant, Niagara). The program is administered directly by the Ministry of Health and admission is restricted to patients from the psychiatric hospital. There are several Homes for severely mentally retarded children.

Lodging houses and residential hotels provide group living with the minimum of restrictions for people in various states of health, some of whom suffer from mental confusion, mental retardation, alcoholism, malnutrition and loneliness. Although local health authorities encourage such people to seek medical help where required, the fear of institutionalization prevents some from seeking help. At present it is difficult to provide on-going adequate supervision in such lodgings. A.P.S. has identified 434 lodging house beds. Senior Citizens Apartments in Hamilton are operated by the Hamilton Housing Authority, an agent for Ontario Housing Corporation. There are 1746 units, mostly one bedroom units with some set aside for couples.

Domiciliary Services

Several services exist to help people remain in their own homes. The Hamilton and Wentworth County Home Care Program administered by the Victorian Order of Nurses (V.O.N.) provides skilled nursing care, homemaker services, physiotherapy and other help under the direction of a physician, and at no direct cost to the patient. This service was designated to avoid admission to a general hospital or to promote early discharge. It is funded by the provincial government as an alternative to hospital care and therefore is essentially a short term program. However, nursing care by the V.O.N. or St. Elizabeth's Visiting Nurses Association can be requested by a physician at any time and Homemaker Services are also available, but at a charge to the individual.

At the core of the provision of health care to the community is the practising physician. Whether he treats his patient in his office, at home, in hospital or other institution, the responsibility for quality of care, appropriateness of therapy, guidance of the patient and family, and identification of a long term care institution rests primarily with him. There are 881 licenced physicians in this district (according to the most updated lists) of whom 411 are specialists.

Regional Planning by Health Councils

With such a broad spectrum of services and health professionals involved it is not surprising that problems of communication and coordination should arise, making identification of the needs and planning for new services very difficult. Regional planning has long been recommended in many countries and was specifically recommended by the Ontario Council of Health.[5] The Ministry of Health has recently announced its decision to develop District Health Councils.[6]

However, more than 7 years ago the five general hospitals in this area began meeting on a regular basis. The Executive Director, Chief of Medical Staff and Chairman of Board of Directors of each hospital met monthly to discuss plans and programs. They formed the Hamilton Hospital Council and later with the addition of representatives from McMaster University, McMaster University Medical Centre,

[5] Report of the Ontario Council of Health on Regional Organization of Health Services, June, 1970.

[6] An Implementation Plan for the New Orientation and Structure of the Ministry of Health, August, 1972.

Mohawk College, the Medical Officer of Health (Hamilton) and smaller hospitals it was renamed the Hamilton District Health Council. The Council on a voluntary basis obtained some remarkable achievements. It was decided to avoid competing for scarce resources but to share them, so that while one hospital developed a unit for treatment of burns, another developed a Renal Dialysis Unit, or a cardiac surgery investigation unit and other services. Shared laundry services, computer services and laboratory services are being developed. Participation by the McMaster University Health Sciences Division in regional planning of resources, and in regional education programs has lent impetus and support.

One of the concerns of the Health Council has been to promote the optimal utilization of services to help people with disabling chronic illnesses. Their needs are complex because in addition to a major physical or psychological disability, they are apt to be socially and economically disadvantaged and to feel unwanted. The identification of these various needs of an individual by health professionals may be incomplete and it may be difficult to find a treatment or support program appropriate to them. To relieve a pressing situation in the home, a physician may in desperation admit a disabled person to a general hospital where not only may the patient not find the appropriate treatment but may also be considered to be misusing that expensive health resource. Even if appropriately admitted, a person disabled by chronic illness may remain beyond the usual length of time in hospital and pressure may mount to move him out to any other locality that can be found. This has resulted in persons being transferred to nursing care or other institutions without careful consideration of their needs or if these can be met, or if the new environment will be tolerable for them. Such transfers may be made in haste yet there may be an adamant refusal to reconsider or re-admit a person if he cannot be adequately managed.

Extended Care Committee and the Assessment and Placement Service

The Extended Care Committee of the Hamilton District Health Council was set up to study these problems. It was suggested that facilities so inappropriately used could, with the help of a coordinating professional and administrative group, work cooperatively to provide efficient and humane health care. The Assessment and Placement Service (A.P.S.) was established by the Hamilton District Health Council based on this recommendation of the Extended Care Committee with the aims of (a) promoting better assessment of the needs of persons with long term disabilities utilizing the personal physician and other health personnel closely associated with the patient. (b) finding appropriate programs that could meet these needs and identifying whatever modifications or new approaches might be required and (c) providing a resource for the education of health personnel in the complex needs of the chronically ill and handicapped. The A.P.S. was funded by the Ministry of Health of Ontario in April 1971 and began operations in September of that year under the supervision of the Extended Care Committee.

Staff of A.P.S.

The Medical Director was appointed by the Health Council to give direction to the Service with an administrator, a social worker, with a background in community services, a nurse with psychiatric experience, an information coordinator and data analyst with training in psychology and computer analysis, and a secretary. A primary task was to gain acceptance by health professionals as well as informing physicians, nurses, social workers, and others by public addresses, by letters and announcements, and by many telephone discussions. At the same time the staff

gained acquaintance with the facilities, staff and programs for all types of health services. Table 1 shows the number of structured visits made to various institutions during the year. In addition, reports were given to out-of-town groups and visits were received from health professionals from Canada, U.S.A. and elsewhere. The best selling technique was by providing service for an applicant or client either through giving information and advice or through finding a placement in an appropriate program.

Assessment Form

It was necessary to work out a method of achieving an adequate assessment of each person's needs that would be carried out by the physician and other health professionals who knew the person, his family and the community he lives in. A form was gradually developed that recorded information in three areas:

a) the age, sex, marital status, next of kin, education, employment and cultural background, previous accommodation and income level are usually recorded by a social worker if the person is in a hospital, or a public health nurse if the person is living at home;

b) the medical diagnosis, prognosis, treatments required, medications, the level of cognitive functioning and emotional status are recorded by the personal physician who also indicates if he will continue the provision of care in the new placement;

c) the ability of the person to see, hear, communicate, feed, dress, bathe, be continent, walk and manage household tasks is recorded by nurses in hospital or other institutions and by a public health nurse if the person is at home.

In an endeavour to promote a team approach the respondents are asked to give a collective recommendation of the placement they consider is required and to indicate if the individual and family are informed and what their reaction is. These questions are asked in such a way that they can be answered by a tick or a few words and so the responses can be coded for computer use. Additional comments are welcomed but a basic picture can be obtained from the questions asked. Questions asked in admission forms for all local institutions are included with the aim of obviating the need for more than one universal form for entry into any treatment program.

On the basis of this information and by knowing intimately the programs and the staffs of the various health facilities from rehabilitation units and psychiatric services, to the Home Care Program and nursing homes, it is possible for the A.P.S. team to recommend the most appropriate placement. In a few cases further information is obtained by visiting the patient but more often clarification or further details can be obtained by telephone. Recommendations may include suggestions of change in therapy or further investigation or consultation as well as indicating appropriate treatment programs or what vacancies are available for suitable institutional care.

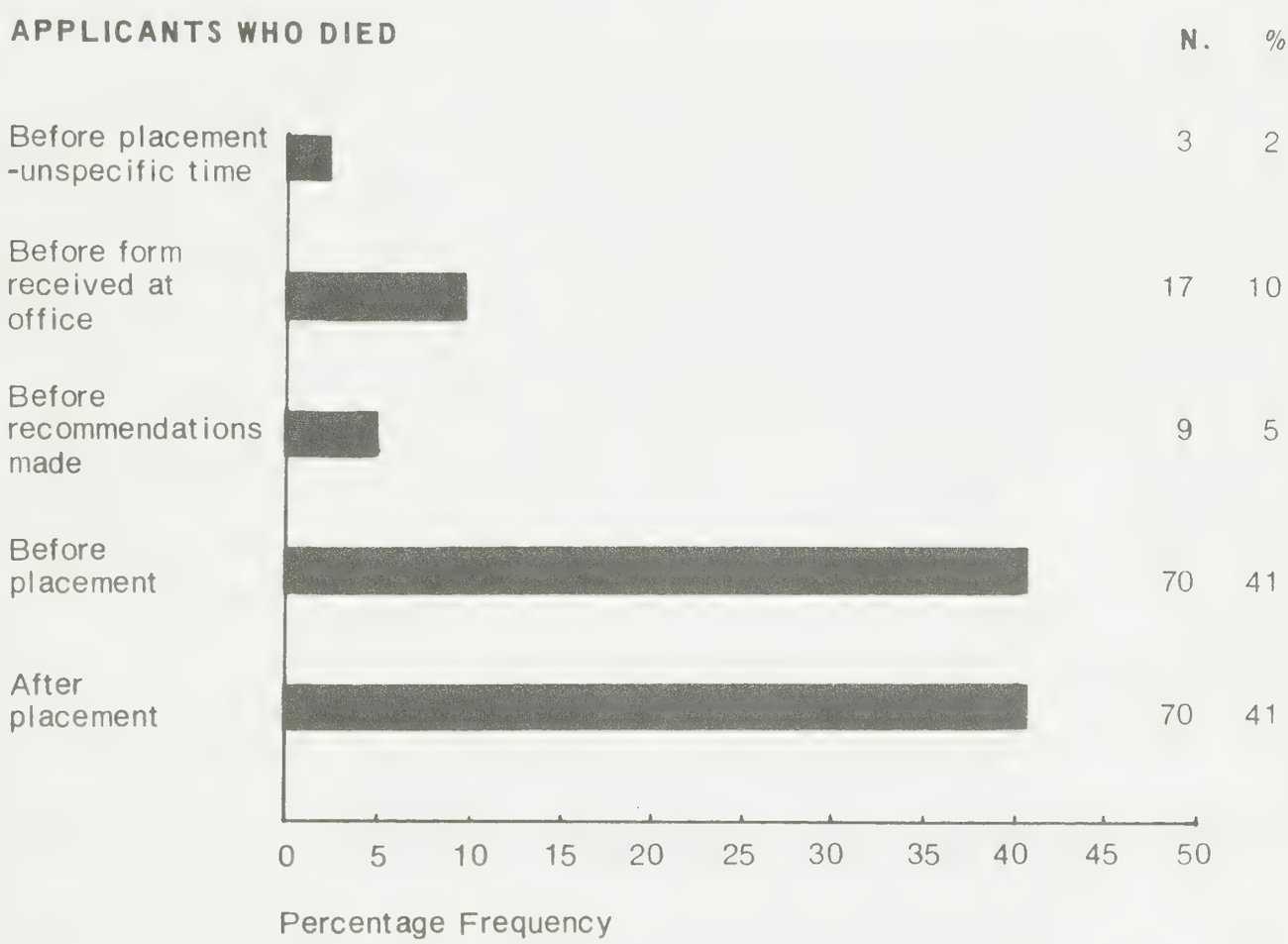
TABLE 1 — PUBLIC RELATION VISITS *

	Hamilton District Health Council Region	Other Regions	Total
GENERAL HOSPITAL (Usually Social Service Depts.)	16	3	19 (9)
CHRONIC HOSPITALS (Social Service, O.T., Physio-therapy, A & D, Personnel)	17	2	19 (9)
REHABILITATION UNITS	4		4 (2)
NURSING HOMES (at least one contact for each)	42	3	45 (20)
HOMES FOR THE AGED	10	2	12 (5)
LODGING HOUSES, C.N.I.B. and other Special Residences or Hostels	9		9 (4)
PSYCHIATRIC FACILITIES	17		17 (8)
COMMUNITY SOCIAL SERVICE AGENCIES	41	1	42 (19)
COUNTY AND MUNICIPAL WELFARE DEPTS.	7		7 (3)
PUBLIC HEALTH DEPT.	9		9 (4)
PROVINCIAL GOVERNMENT (Health Ministry Employees)	8		8 (4)
OTHER PROVINCIAL GOVERNMENT DEPTS.	2		2 (1)
FACULTY OF MEDICINE, McMaster University	2		2 (1)
INDIVIDUAL STUDENTS (Medical, Nursing & Other)	12		12 (5)
SEMINARS	5		5 (2)
CONFERENCES		4	4 (2)
ANNUAL CONVENTIONS	6		6 (3)
TOTAL			222 (101)

* ( ) indicates column percentages

Much of the service provided by A.P.S. is informational. In some cases the caller wishes to understand the resources available and what costs are involved. Even if help is requested for placement in a program and the assessment is carried out the recommendations may not be followed because a) the patient himself disagrees or delays, b) knowing that placement will be possible through A.P.S. the patient and family feel reassured and postpone further action, c) the condition of the patient worsens and he dies before placement (see Graph 1), d) in a number of cases other arrangements are made without informing A.P.S.

GRAPH 1 - STAGE AT WHICH APPLICANTS DIED IN A.P.S. REFERRAL AND PLACEMENT PROCESS



TOTAL NUMBER WHO DIED..... 169

Participation in the A.P.S. is voluntary for applicants, families, physicians and nursing homes, Homes for the Aged, and other facilities. Reversion to the old system of trying to get a patient into a bed in some nursing care institution ahead of other patients and other hospitals occasionally occurs. This is becoming more uncommon because the recipient institutions are requesting that all referrals to them be through the A.P.S. In some instances the patient is sent home to relatives who may be completely unable to cope. The patient may then be referred again to A.P.S. or may be readmitted to the same or another hospital.

Number of Applications

During the 12 month period September 1, 1971 to August 31, 1972, there were 1482 applications to A.P.S., of which 227 (16%) were brief contacts for information

or to initiate the referral process. In 119 (8%) the assessment form was not completed fully but some of these cases are still active. In 1136 (77%) a full assessment was achieved and recorded.

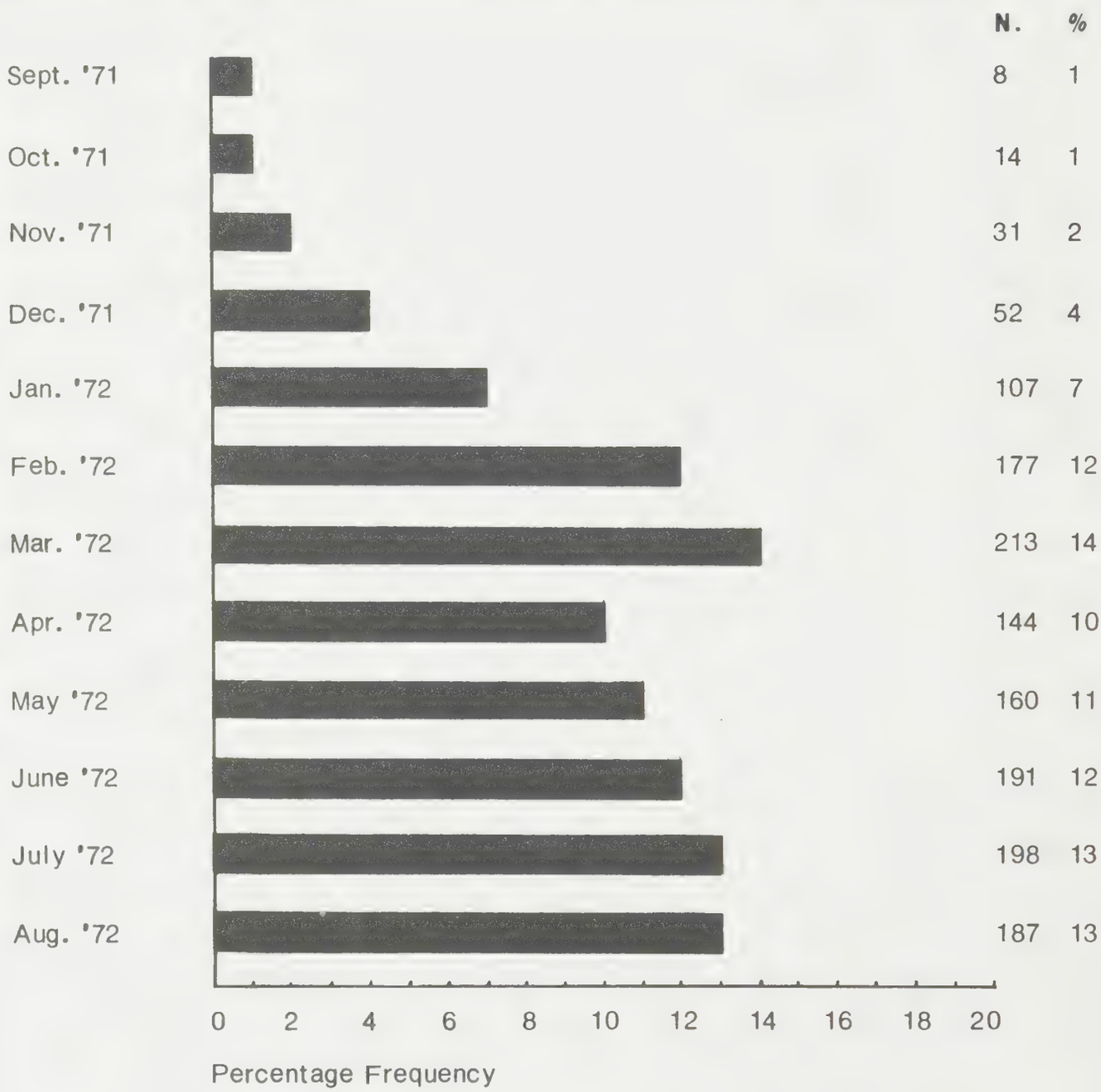
Graph 2 shows the number of applications by month, and the growth of the service from 8 to approximately 200 per month.

Procedure

The procedure followed by the A.P.S. from the first contact to placement involves 3 stages:

Stage I: On receipt of an enquiry by telephone the name of the caller, the name of the applicant, address, phone number, name of the physician, and the nature of the problem is noted by the secretary. Note is made if any community services are already involved. If more than information is

GRAPH 2 - NUMBER OF APPLICANTS TO A.P.S. BY MONTH



TOTAL NUMBER OF APPLICANTS ... 1482

required, the assessment form is sent out for completion with an explanatory letter to the appropriate health professionals. Hospital social service departments have the form already so not infrequently the initial contact is made by receipt of a completed form. Where the person is at home the form must be completed by the family physician and usually by a public health nurse.

Stage II: On return of the completed form the case is assigned to one of the staff consultants (a Social Worker and a Registered Nurse) who reviews it, makes further enquiries as required, and then after discussion with other staff when needed, sends recommendations back to the referring physician or hospital staff, and others involved in the application.

Stage III: The actual decision on placement is made by the person with the family and the health professionals. As discussed above, the placement may not take place or may be delayed. An obvious cause of delay is unavailability of accommodation in long stay institutions.

Time for Procedure

The time required for the 3 stages varies greatly (see (Table 2). When the arrival of the completed form is the first contact the time lapse is zero, which was the case in 643 or 58% of the 1135 referrals where completed forms were received. This stage has also taken as much as 142 days. The mean number of days from first contact to receipt of the completed form is 8 days for all referrals and the same for those people who were actually placed. Sometimes the information on the form is not clearly detailed (or is illegible) or there are discrepancies. Sometimes the physician and nurse differ radically on the degree of impairment of mental function and further enquiry can lead to more communication between them or to clarification of misjudgment. On one occasion the physician had made a diagnosis of severe mental retardation in a non-communicating young adult. The assessment form indicated that the person had completed 8 years of schooling in 8 years so further enquiry was made. This led to further investigation and diagnosis of an adjustment problem with depression and hostility. A quite common problem is the

TABLE 2 - LENGTH OF TIME IN DIFFERENT STAGES OF THE REFERRAL AND PLACEMENT PROCESS :

STAGES	LENGTH OF TIME		
	LONGEST NUMBER OF DAYS	SHORTEST NUMBER OF DAYS	MEAN NUMBER OF DAYS
Time between 1st contact with A.P.S. & when A.P.S. received completed referral form	142	0	8
Time between receipt of completed referral form and first recommendation made by A.P.S.	132	0	1
Time between first recommendation being made and actual placement of applicant	185	0	15
TOTAL	459	0	24

TABLE 3 - DAYS BETWEEN FIRST RECOMMENDATION MADE AND ACTUAL PLACEMENT BY NEED OF ADDITIONAL INFORMATION *

		ADDITIONAL INFORMATION		
		YES	NO	TOTAL
DAYS between first recommendation made and placement	0-7	(40) 177 (53)	(58) 159 (47)	336
	8+	269 (60) (70)	116 (42) (30)	385
	TOTAL	446	275	721

* The top ( ) indicates column percentages, and the bottom ( ) indicates row percentages.

disturbed, confused, usually elderly person, who is upsetting the staff and patients in a general hospital ward. Although this is a serious problem for the hospital it can usually be resolved by accurate diagnosis and appropriate medication. The risk of death for elderly confused people is quite high and management requires real skill. However, control can be achieved and where the confusion is related to an acute illness it may clear up completely with recovery from that illness. Transfer of the patient can be dangerous as the move itself may cause deterioration and death. The A.P.S. staff therefore do not recommend movement of such patients but rather adequate treatment and may suggest specific medications. On some occasions such advice has enabled a person already in a nursing home to remain there with adequate control, thus avoiding the rigours of a transfer to a general hospital or other location. Analysis of 1,100 assessment forms shows that further information was required in 681 or 61% and particularly from extended care psychiatric facilities where more information was needed in 78% of their referrals. Patients on whom further information was required took somewhat longer to place. It was needed for 53% of people taking less than 7 days from the recommendation being made to actual placement as compared to 70% of people taking 8 days or more (see Table 3). The time required for Stage II has varied from zero to 132 days for the 1054 cases where review and recommendations were made, with a mean of 1 day. This mean time for Stage II was the same for the people actually placed. The time required for Stage III is also variable, ranging from zero (placement same day as recommendation made) to 185 days with a mean of 15 days for the 728 cases actually placed. It should be remembered that individuals and families may almost indefinitely postpone acceptance of placement, in a suitable program or institution, as well as the fact that a vacancy in a suitable program may be difficult to find.

Physicians' Utilization

The service was utilized by a large number of physicians. Out of approximately 880 registered physicians in the area, a number of whom are not in private practice, only 77 did not participate. A physician was identified in 1406 out of the total of 1482 referrals including brief services. This would indicate that almost all persons could name a personal physician to whom reference could be made. The physician was not necessarily involved unless placement or other action was required. No action was taken by A.P.S. without information from the assessment form and a

physician was then invariably involved. Some physicians used the service quite intensively. 54 used it more than 5 times; 25 used it more than 10 times; 4 used it more than 25 times; and 1 used it 41 times. First contact with the A.P.S. was usually not by a physician.

Table 4 shows that 163 applications or 11% of 1468 were initiated by physicians (usually the family physician) whereas 382 applications (26%) were from a client, family or friends. 125 (9%) were from community professionals such as public health nurse, Home Care, or social service agency staff; 550 applications (37%) came from general hospitals staff (excluding physicians) and 248 (17% from a non-physician in the psychiatric hospital or a long stay institution.

TABLE 4 - PERSON REFERRING APPLICANT TO A.P.S.

PERSON	N.	%
Physician	163	11
The patient's relative or friend	382	26
A Community Health Professional	125	9
A General Hospital staff member (non-physician)	550	37
A Psychiatric Hospital or Long Stay facility staff member (non-physician)	248	17
TOTAL	1468	100

Characteristics of Applicants

The Assessment and Placement Service assessment form enables an analysis to be made of persons needing help in finding a program appropriate to their needs. All the information was not recorded on the form in every instance and so the total number varies, in different categories. The bulk of this report, the graphs and tables refer to *applicants* to A.P.S., which is to be differentiated from *people* who made an application(s) to A.P.S. A person may make several applications to A.P.S. for assessment, resulting in several assessment forms completed on the same person at different points in time. The term "applicant" is used to indicate that each application to A.P.S. (whether for information only, a partial or a complete assessment) is counted separately and not grouped together although some may refer to the same person two, three, or more times. Except where otherwise indicated, all graphs and tables refer to applicants, not individual people.

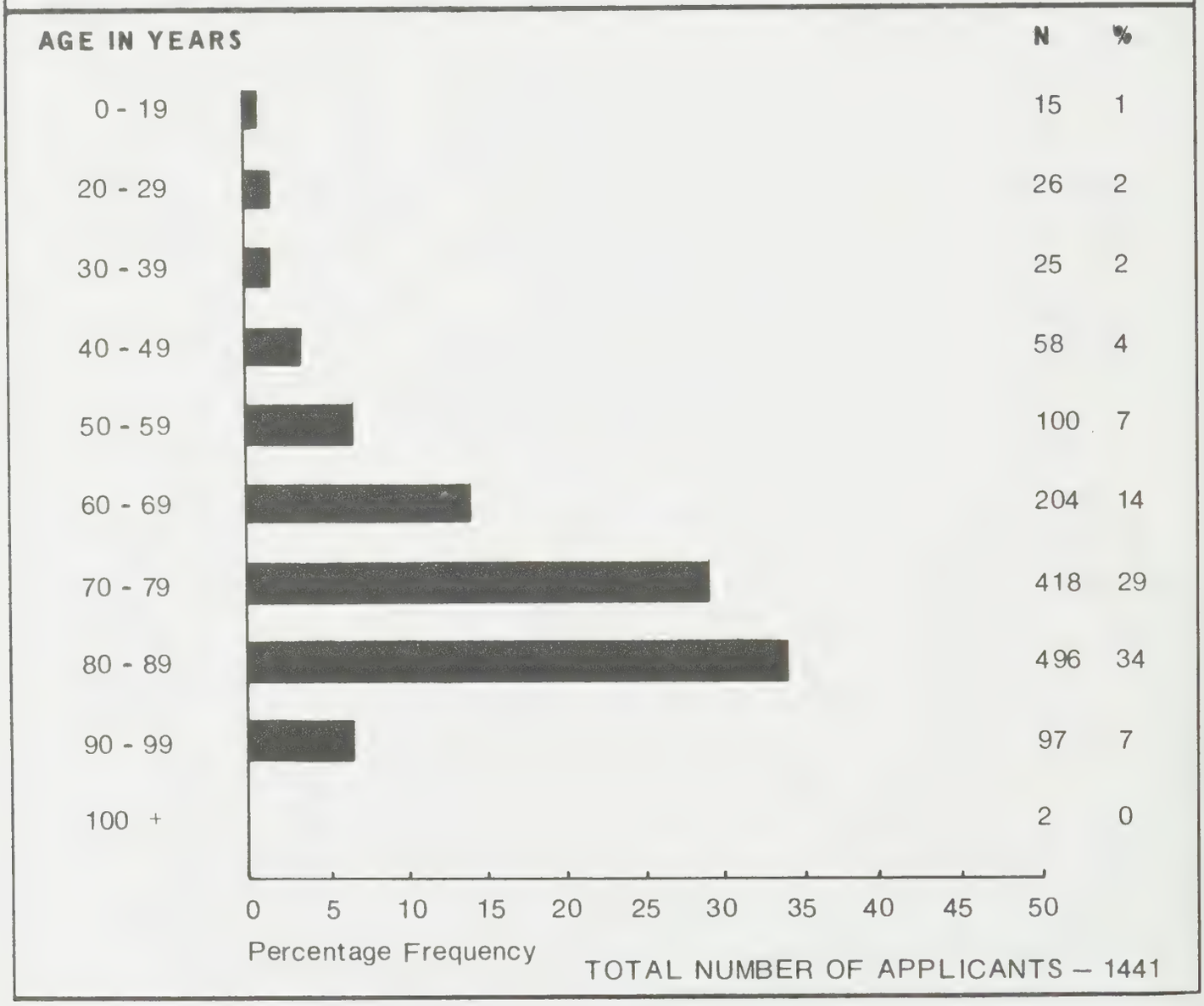
Out of 1483 applicants, 588 were male (40%) and 895 (60%) were female. According to the 1971 Census (Advance Bulletins), the breakdown for sex in the Wentworth census division (Hamilton and district), is 50% male and 50% female.

Graph 3 shows the age distribution for 1441 applicants. It is notable that the largest number were in the 9th decade: 496 applicants or 34% of the total. The 8th decade was next having 418 applicants or 29% of the total. There were 1217 applicants over the age of 60 or 84% of the total and 2 were 100 years of age or more. However, 15 applicants were less than 20 years of age.

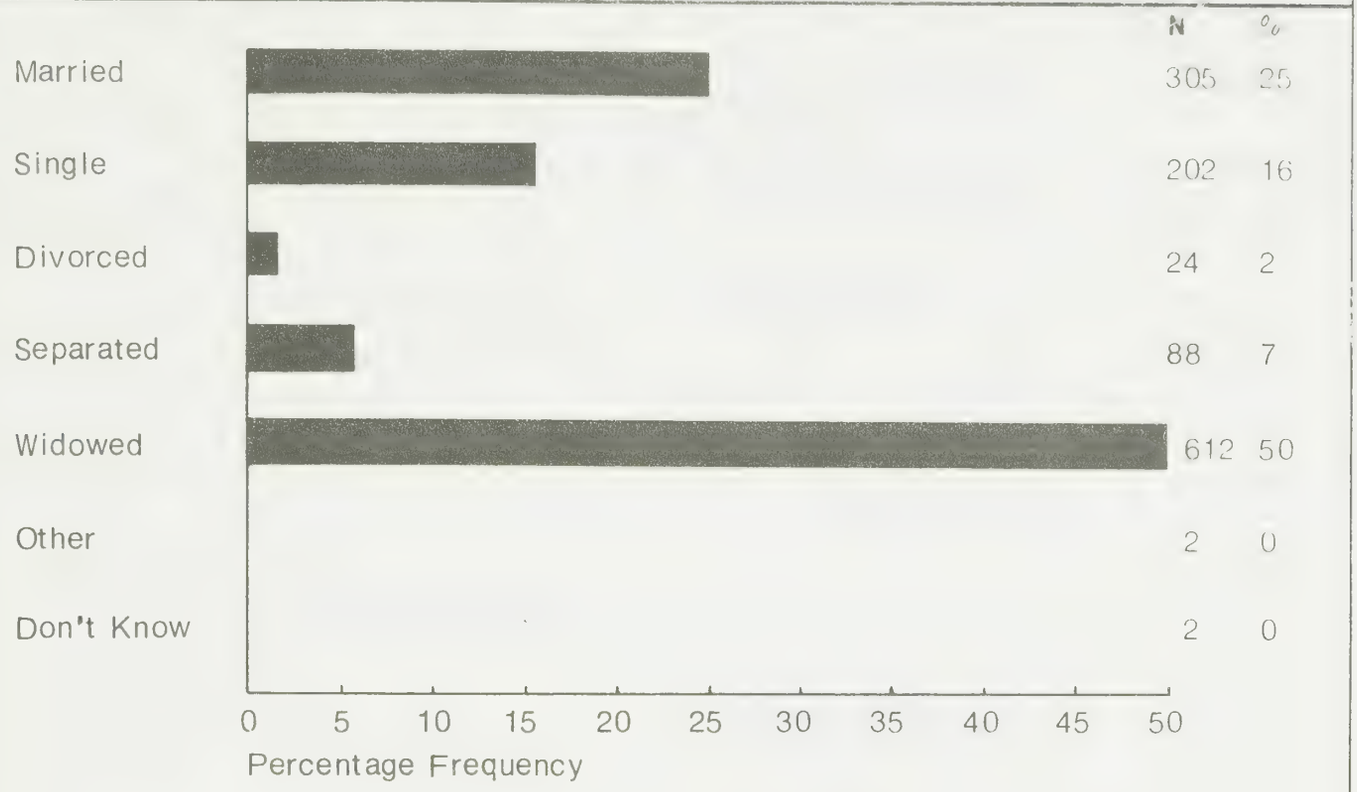
Graph 4 shows the marital status of 1235 on whom this was recorded. 612 or 50% were widowed. With the widowed, single, divorced and separated combined, they make up 75% of the total who, in the event of illness, might lack someone to help. According to the 1971 Census (Advanced Bulletins), for the Census division of Wentworth (i.e. Hamilton and surrounding district), the marital status for the total population is as follows: 45% were never married (27% if you include only those over the age of 15 years), 49% are married, (includes separated), 5% are widowed, and 1% are divorced. For the total population in this district, 33% are either single (over 15 years of age), widowed or divorced.

According to A.P.S. data, the widowed are preponderantly women, because women generally outlive men and are usually younger than their husbands: (see Table 23 in Appendix). It is important to identify a next of kin to inform about the requirements of a handicapped person. In 1292 applications a next of kin was named in 1276 or 99%. 16 applicants lacked any next of kin, or close friend.

GRAPH 3 - AGE DISTRIBUTION OF APPLICANTS TO A.P.S.



GRAPH 4 - MARITAL STATUS OF APPLICANTS TO A.P.S.



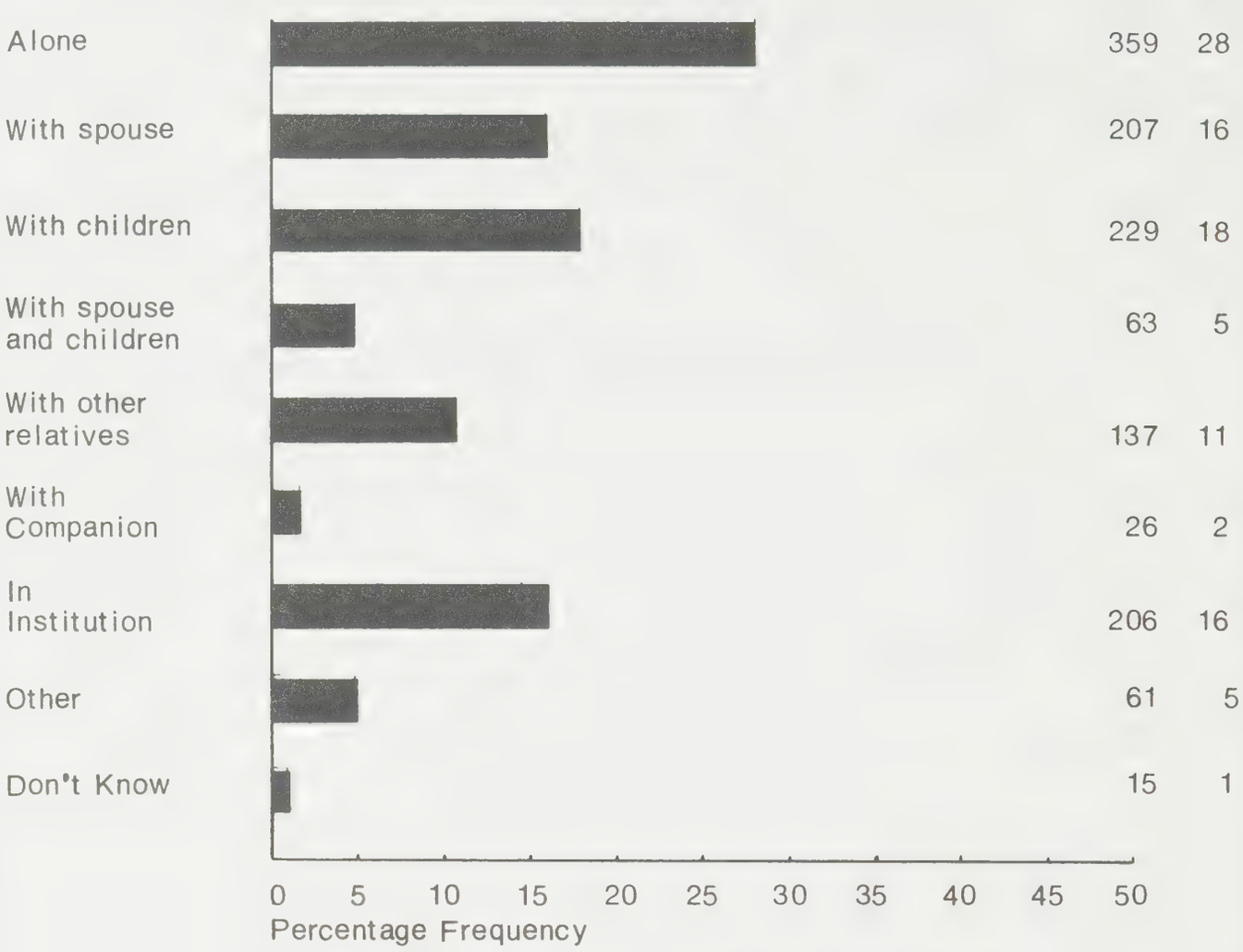
TOTAL NUMBER OF APPLICANTS – 1235

The ability of a handicapped person to remain or return home will be affected by with whom he was living at the onset of the condition that precipitated referral and if that person at home could assist with (A.D.L.) activities of daily living (feeding, washing, dressing, bathing, etc.). Graph 5 shows that of 1303 applicants, 359 or 28% were living alone. 207 or 16% were in an institution. We should note that only 63 applicants or 5% lived with spouse and children, whereas 207 (16%) lived with spouse and 229 (18%) lived with children. Presumably having a spouse enabled a person to live apart from children but if one had no spouse then one would accept living with children or relatives. The ability of a person in the home to assist is revealed in Graph 6. In the 1081 applications where this aspect was noted, 43 handicapped applicants (4%) had someone at home but that person could not give any such assistance with A.D.L. 375 applicants (35%) had no one at home.

Enquiry was made about income and is recorded in Graph 7. The figures are not very accurate as it does not stipulate if both Old Age Pensions are included for married couples, for instance. We note that 67 applicants or 6% denied any income, whereas 57 or 5% had over $400 per month.

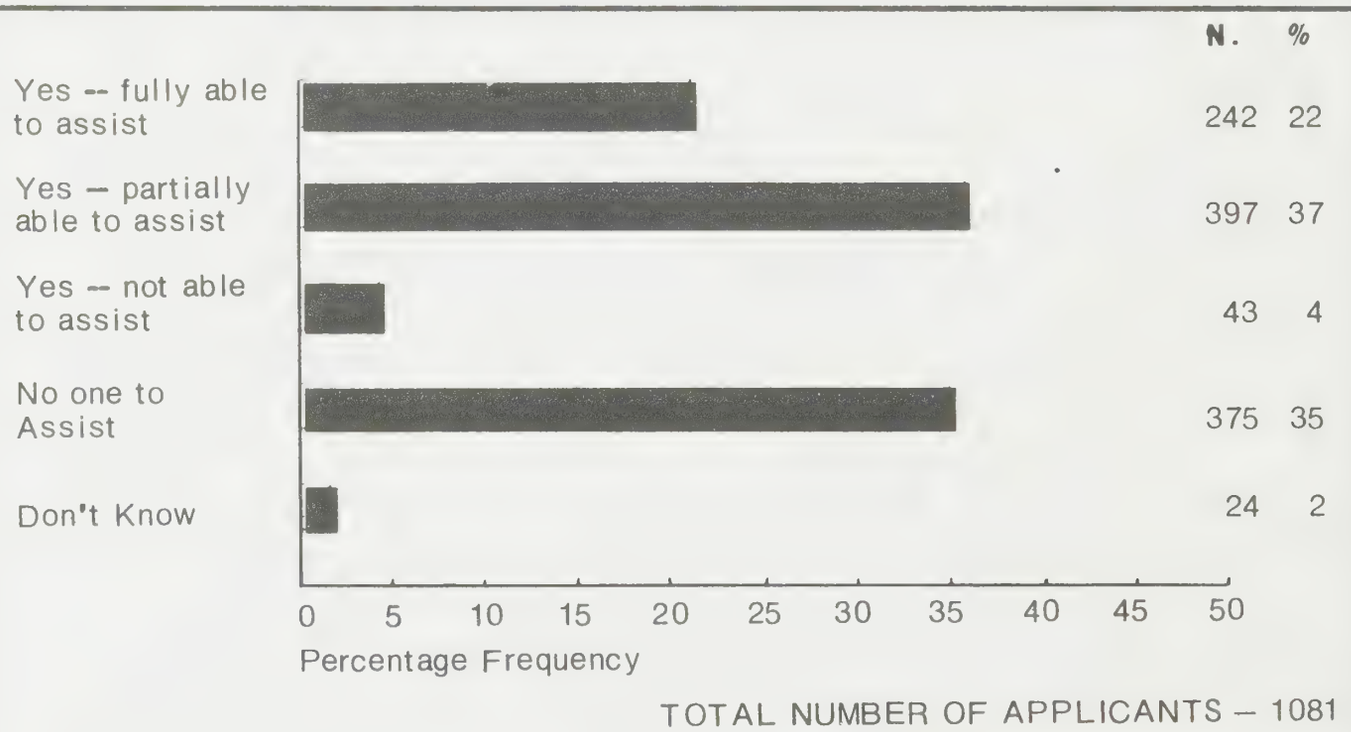
In considering institutional placement the background of the person is of importance and his ability to be understood in English or another language. Staff in nursing homes and other long stay institutions may speak other languages but special efforts are made by A.P.S. to ensure there will be someone who can speak with the person on the staff and among other residents even (or especially) if the person is somewhat confused. In 1175 applicants for whom the question was answered, 1122 or 95% understood English and 53 applicants did not. 215 applicants were recorded as speaking other languages, of whom 20% spoke Italian, 14% French, 14% Polish, 6% German and 47% spoke a variety of other languages. Of the 53 applicants who did not speak English, 43% spoke Italian, 9% spoke Polish, 4% spoke German, 2% spoke French but 42% spoke other languages. The 1971 Census

GRAPH 5 - WITH WHOM THE APPLICANT WAS LIVING AT ONSET OF PRESENT EPISODE



TOTAL NUMBER OF APPLICANTS – 1303

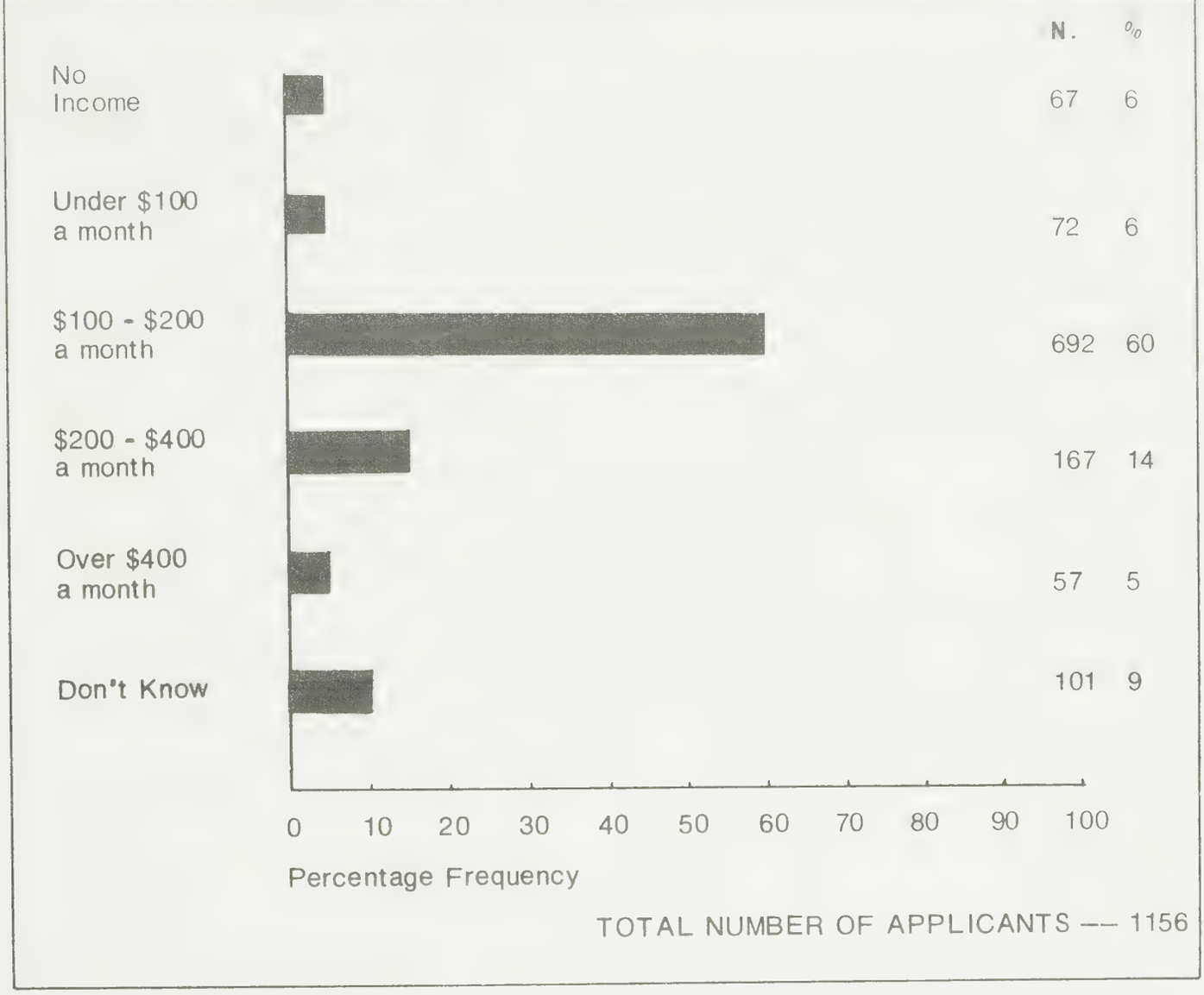
GRAPH 6 - WAS THERE ANYBODY TO ASSIST THE APPLICANT IN ACTIVITIES OF DAILY LIVING?



TOTAL NUMBER OF APPLICANTS – 1081

(Advanced Bulletins) recorded 78% of the people in the Census division of Wentworth (Hamilton and district) as having English mother tongue. Of the 23% whose mother tongue was not English, the breakdown is as follows: 2% French, 2% German, 7% Italian, 1% Netherlands, 2% Polish, 2% Ukrainian and 7% other mother tongues.

GRAPH 7 - INCOME DISTRIBUTION OF APPLICANTS REFERRED TO A.P.S.



Previous Employment

Another item of background information recorded was previous employment. Considering the age distribution seen in Graph 3, it is not surprising that of 1098 applicants for whom this is recorded, 546 or 50% were retired, 225 or 20% were reported as being housewives, and 121 or 11% were unemployed. 72 applicants or 6% had been employed part or full time up to the onset of the illness episode that led to application being made. 73% of the applicants stated their religion as Protestant, 23% Roman Catholic, 2% Jewish, 2% other.

Medical Diagnosis

We may now consider the nature of the illness from which applicants to A.P.S. suffered. In completing the assessment form the physician is asked to record the diagnoses in order of importance along with the date of its first appearance and the date of the onset of the episode leading to this application being made. Although a diagnosis was usually listed, not infrequently no dates were given which made it

difficult to know for example when a hip fracture had occurred and so to estimate if weight bearing would soon be possible. The prognosis for improvement in a state of confusion and disorientation is very different if it is of recent origin in a previously mental competent person, than if it has been gradually developing over some years. The diagnosis of the cause of impairments in judgment, memory, mood and behaviour was often vague. The terms "senile", "senility", "cerebral arteriosclerosis" were used it seemed interchangeably. It was decided therefore to deal with these in a uniform way. If information on the form suggested that deterioration of memory and judgment had been gradual in development with changes in the personality and if there was no mention of cerebrovascular accident, and if the person was reported to be ambulant then the diagnosis of "Senile Dementia" was made. If alcoholism was the underlying cause of brain damage, this was diagnosed as "Alcoholic Psychosis". Where impairment in judgment and memory was reported other than as above the diagnosis was made of psychosis due to other cerebral condition, and if a stroke or other evidence of cerebrovascular disease was indicated the secondary diagnosis of cerebrovascular disorder was added. In cases of stroke where the physician did not diagnose mental impairment, the primary diagnosis of cerebrovascular disease was coded. All neoplasms were recorded and coded according to the organ system affected. All cases of Diabetes Mellitus were recorded. To simplify the diagnoses, categories were based on the International Code and diseases grouped to provide a listing and coding for the commonest reported.

Table 5 shows the 12 commonest primary and secondary diagnoses listed in 1182 assessment forms.

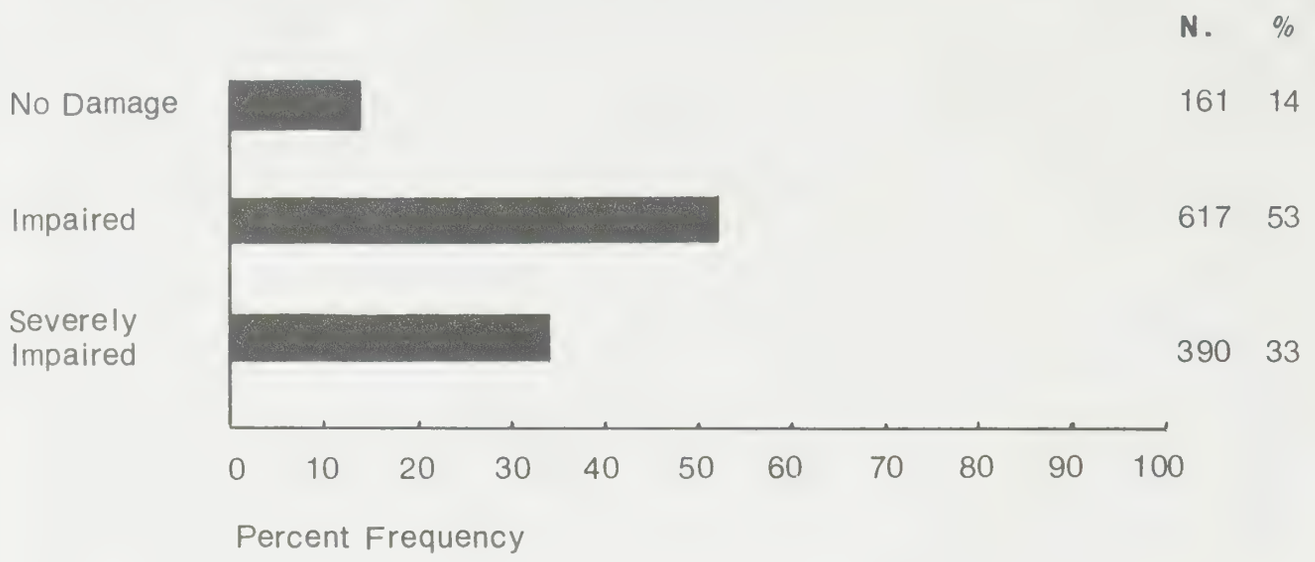
It is evident that degenerative diseases affecting the central nervous system are most common and that vascular disease is a common cause of disability in its effect on the brain and heart. Malignant tumours, fractures of the leg (chiefly hip) and arthritis are also common. The twelve commonest diagnostic groups accounted for 906 or 78% of all primary diagnoses. Among the secondary diagnoses Diabetes Mellitus, genito urinary problems, and neuroses (especially depression) became common. It is of interest to note that 11 persons suffering from traumatic paraplegia or quadriplegia (usually) were referred.

The competence of psychological function can be estimated from the area of the assessment form that records on 5 point scales; (a) judgment, memory, (b) mood and behaviour. Impairments of the first two, (a), are considered to indicate brain damage, while the second two, (b), indicate psychological functional impairment. Standing alone they may not be regarded as conclusive but should be consistent with the medical diagnosis and reports of function elsewhere in the form to be reliable. The five point scales were grouped into three to indicate "no damage", "impaired", or "severely impaired" for brain damage, and into two to indicate "no impairment" or "impaired" for psychological impairment (mood and behaviour). The level of function in activities of daily living (A.D.L.) were regrouped into three categories. (see Graphes 8, 9, 10).

TABLE 5 — PRIMARY AND SECONDARY DIAGNOSES

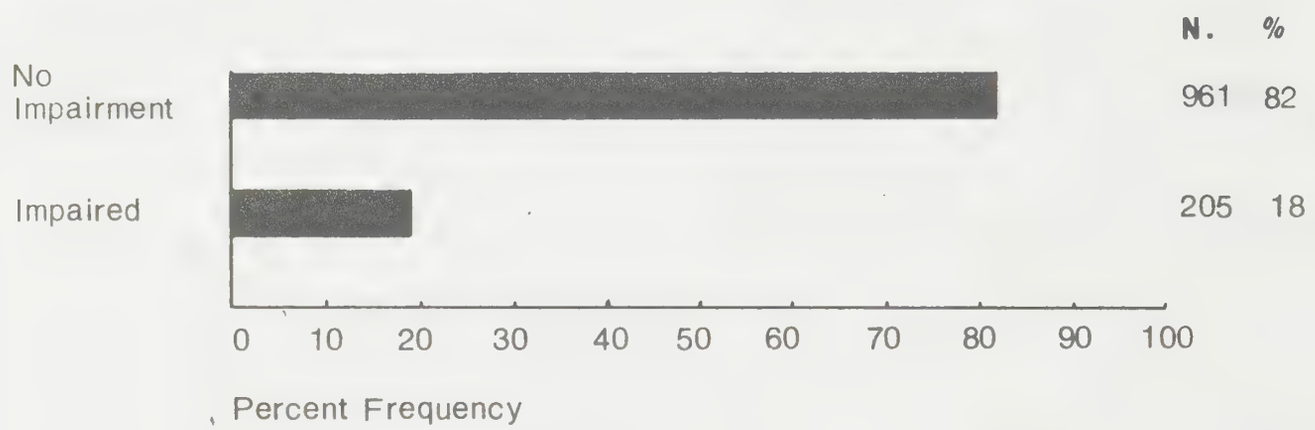
Rank	Primary Diagnosis	N.	%	Secondary Diagnosis	N.	%
1	Senile & Presenile Psychosis	147	12	Cerebrovascular Disorders	122	13
2	Psychosis due to other cerebral condition	143	12	Diabetes Mellitus	96	10
3	Cerebrovascular Disorders	142	12	Ischaemic Heart Disease	87	9
4	Ischaemic Heart Disease	113	10	Psychosis due to other cerebral condition	63	7
5	Tumours (malignant)	85	9	Genito-Urinary tract disease	38	4
6	Fracture lower limb	79	7	Psychoneuroses	37	4
7	Arthritis (all types)	46	4	Respiratory Tract Diseases	32	3
8	Parkinsonism	36	3	Hypertensive Disease	32	3
9	Respiratory Tract Disease	35	3	Digestive Tract Disease	30	3
10	Diseases of Arteries, Veins and Imphatics	28	2	Neoplasms (malignant)	27	3
11	Alcoholism	27	2	Diseases of liver, gall-bladder & bile ducts	22	2
12	Psychoneuroses (including Depression)	25	2	Epilepsy	20	2
	The first 12 Primary Diagnoses represents 78% of all Primary Diagnoses reported (n = 1182 applicants)			The first 12 Secondary Diagnoses represents 63% of all Secondary Diagnoses reported (n = 922 applicants)		

GRAPH 8 - LEVEL OF BRAIN DAMAGE IN APPLICANTS TO A.P.S.



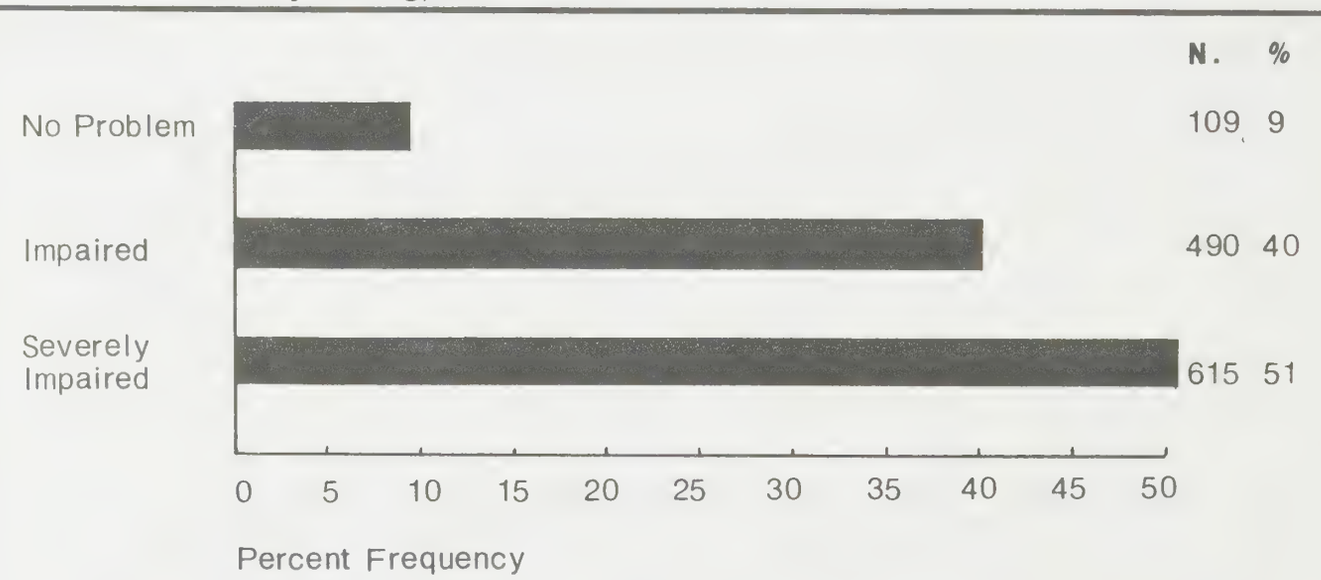
TOTAL NUMBER OF APPLICANTS – 1168

GRAPH 9 - LEVEL OF PSYCHOLOGICAL IMPAIRMENT (Mood and Behaviour) IN APPLICANTS TO A.P.S.



TOTAL NUMBER OF APPLICANTS – 1166

GRAPH 10 - LEVEL OF IMPAIRMENT IN FUNCTIONAL CAPACITY (Activities of Daily Living) in APPLICANTS TO A.P.S.



TOTAL NUMBER OF APPLICANTS – 1214

It is evident that of 1168 applicants only 14% had no evidence of brain damage and 33% were severely impaired. On the other hand functional psychological impairment was reported in only 18%. Depression was not reported as often as would be expected, possibly because brain damage made it less apparent. Impairment in A.D.L. was absent in only 9% of 1214 applications and over half were severely impaired.

Table 6 shows the relationship of brain damage to impairment in A.D.L. function. Only 42 applicants had no problem in either area, whereas nearly 300 or 27% of 1126 applicants had severe impairment in both areas.

TABLE 6 - APPLICANT'S LEVEL OF IMPAIRMENT IN FUNCTIONAL CAPACITY (ACTIVITIES OF DAILY LIVING) BY APPLICANT'S LEVEL OF BRAIN DAMAGE *

BRAIN DAMAGE	FUNCTIONAL CAPACITY (A.D.L.)			
	NO PROBLEM	IMPAIRED	SEVERELY IMPAIRED	TOTAL
No Damage	42 (4)	70 (6)	41 (4)	153
Impaired	48 (4)	308 (27)	238 (21)	594
Severely Impaired	6 (1)	74 (7)	299 (27)	379
TOTAL	96	452	578	1126 (101)

* ( ) indicates percentages of the total

Placement was recommended by A.P.S. based on the needs of the person and whether these needs could be met in a certain locality. Table 7 shows the final recommendations made by A.P.S. by the different age groups. It may be noted that the younger age group tended to be recommended to chronic disease hospitals, while the older group tended to be recommended to Homes for the Aged. The very elderly tended to be recommended to nursing homes because of their frailty and the difficulty Homes for the Aged have in accommodating or finding a vacancy for people needing this level of care.

There were 161 applicants that mentioned a urinary catheter being present, 110 of whom were placed: 49 of these were placed in a chronic disease hospital, 34 in a nursing home, 8 returned home with support services, 5 returned to their own homes with no services, and 3 entered a lodging house. Special attention would be required to ensure proper care and follow-up.

An attempt was made by A.P.S. staff to follow-up one month after placement to judge if it had been satisfactory. Dissatisfaction usually indicated the inability of the applicant to receive the type of care required in the opinion of A.P.S. (even if the applicant expressed no complaint). In some cases the "second best" placement was the final recommendation of A.P.S. because the most desirable program did not exist or had long waiting lists. It was, however, difficult for A.P.S. to carry out the follow-up due to pressure of work. Plans are underway to develop a more adequate follow-up service for persons with long term disability. Of those 598 (40%

of total caseload, and 82% of those placed) who were followed-up, the A.P.S. staff considered the placement satisfactory in 541 or 90%.

TABLE 7 AGE OF APPLICANT BY LEVEL OF CARE THAT WAS RECOMMENDED *

LEVEL OF CARE RECOMMENDED	AGE			
	0 - 59 YRS.	60 - 79 YRS.	80 - 100 + YRS.	TOTAL
Acute treatment hospital	0 (0)	4 (1)	0 (0)	4
Psychiatric hospital	10 (6)	2 (.5)	1 (.5)	13
Rehabilitation unit	8 (5)	19 (4)	18 (4)	45
Chronic Hospital	47 (30)	90 (20)	85 (20)	222
Nursing Home	33 (21)	165 (36)	185 (43)	383
Home for Aged	4 (3)	96 (21)	84 (20)	184
Lodging House	32 (20)	36 (8)	22 (5)	90
Support Services & Other Facilities	22 (14)	46 (10)	28 (7)	96
Home without Services	3 (2)	3 (1)	3 (1)	9
TOTAL	159 (101)	461 (101)	426 (100)	1046

* ( ) in the table refers to column percentages

Further Analysis of Data

A major purpose of A.P.S. is to suggest a program that may enable a handicapped person (a) to remain in the community or, (b) to return to the community from an institution, or (c) to enter an institution from the community, or (d) to enter an institution from another institution (such as a general hospial, for example). For the purpose of this report, an "institution" is defined as including the following health care facilities (or levels of care): acute care hospitals; psychiatric hospitals (acute care and extended care); rehabilitation units (both "special" and "general"); chronic hospitals; nursing homes; and Homes for the Aged (bed care, special care and normal care sections). The "community" or non-institution is defined as including: lodging houses; special living facilities such as hostels, etc.; support services such as V.O.N., St. Elizabeth Nurses, Public Health Nurses, Meals on Wheels, Homemakers, etc.; other services such as Day Therapy Centres, Community Psychiatric Teams, Adult Training Centres, etc.; and home with no formalized service being provided. The following tables show some of the characteristics of the people (individuals who perhaps have made more than one application to A.P.S. but where

only one is counted) and of the applicants (includes every application to A.P.S. whether or not the same person is included twice or more), in these four categories of patient movement. Table 8 shows the number and percentage of people in these categories of patient movement and Table 9 shows the number and percentage of applicants.

TABLE 8 - PEOPLE: PATIENT MOVEMENT (Level of Care Patient was Referred from by Level of Care Patient was Placed in) *

REFERRAL LOCATION	PLACEMENT LOCATION		
	INSTITUTION	COMMUNITY	TOTAL
Institution	357 (76) (54)	112 (24) (17)	469
Community	86 (45) (13)	107 (55) (16)	193
TOTAL	443	219	662

* The top ( ) in each square gives the row percentage, and the bottom ( ) gives the percentage of the total.

Tables 10, 12, 14, 16 (even numbers) show various characteristics of the people in each category of patient movement along with the percentage of all people having that characteristic (e.g. the number of people living alone who moved from one institution to another and the percentage of all people living alone), as well as the percentage of all such placements (e.g. the number of people living alone who moved from one institution to another and the percentage of all people so moved). Tables 11, 13, 15, 17 (odd numbers) show the same characteristics for the 4 categories of patient movement but deals with applicants (may include the same person twice or more) rather than people and give the percentage of all such placements (e.g. — the number of applications where the person had lived alone and moved from one institution to another, and the percentage of all applicants so moved).

TABLE 9 - APPLICANTS: PATIENT MOVEMENT (Level of Care Patient was Referred From by Level of Care Patient was Placed in)*

REFERRAL LOCATION	PLACEMENT LOCATION		
	INSTITUTION	COMMUNITY	TOTAL
Institution	404 (77) (55)	121 (23) (17)	525
Community	94 (46) (13)	111 (54) (15)	205
TOTAL	498	232	730

* The top ( ) in each square gives the row percentages, and the bottom ( ) gives the percentage of the total.

TABLE 10 - PEOPLE: Patient Movement (Level of Care Patient was Referred From and Level of Care Patient was Placed In) by Who the Patient was Living with at Onset of Present Episode *

PATIENT MOVEMENT	PATIENT LIVING								TOTAL
	ALONE	WITH SPOUSE	WITH CHILDREN	WITH SPOUSE & CHILDREN	WITH OTHER RELAT'S	WITH COMPAN-ION	IN INSTITUT-ION	OTHER	
Institution to Institution	100 (29) (50)	61 (18) (50)	60 (17) (53)	21 (6) (58)	26 (7) (39)	3 (1) (21)	68 (20) (87)	9 (3) (43)	348 (101)
Community to Institution	26 (23) (13)	23 (21) (19)	26 (23) (23)	7 (6) (19)	15 (13) (23)	7 (6) (50)	4 (4) (5)	4 (4) (19)	112 (100)
Institution to Community	36 (43) (18)	16 (19) (13)	10 (12) (9)	4 (5) (11)	12 (14) (18)	1 (1) (7)	4 (5) (5)	1 (1) (5)	84 (100)
Community to Community	40 (37) (20)	21 (20) (17)	17 (16) (15)	4 (4) (11)	13 (12) (20)	3 (3) (21)	2 (2) (3)	7 (7) (33)	107 (101)
TOTAL	202 (101)	121 (99)	113 (100)	36 (99)	66 (100)	14 (99)	78 (100)	21 (100)	651

* The top ( ) in each square indicates row percentages and the bottom ( ) in each square indicates column percentages

TABLE 11 - APPLICANTS: Patient Movement (Level of Care Patient was Referred From and Level of Care Patient was Placed In) by who the Applicant was living with at Onset of Present Episode. *

PATIENT MOVEMENT	APPLICANT LIVING								TOTAL
	ALONE	WITH SPOUSE	WITH CHILDREN	WITH SPOUSE & CHILDREN	WITH OTHER RELAT'S	WITH COMPAN-ION	IN INSTITUT-ION	OTHER	
Institution to Institution	111 (28)	66 (17)	69 (18)	22 (6)	28 (7)	4 (1)	81 (21)	9 (2)	390 (100)
Community to Institution	26 (22)	27 (23)	29 (24)	7 (6)	15 (13)	7 (6)	4 (3)	5 (4)	120 (101)
Institution to Community	40 (43)	16 (17)	13 (14)	4 (4)	12 (13)	2 (2)	4 (4)	1 (1)	92 (98)
Community to Community	41 (37)	22 (20)	17 (15)	5 (5)	13 (12)	3 (3)	2 (2)	8 (7)	111 (101)
TOTAL	218	131	128	38	68	16	91	23	713

* ( ) indicates row percentages

TABLE 12 - PEOPLE: Patient Movement (Level of Care Patient was Referred From & Level of Care Patient was Placed In) by Someone Able to Assist the Patient in the Activities of Daily Living *

PATIENT MOVEMENT	SOMEONE ABLE TO ASSIST PATIENT IN A.D.L.				
	YES - SOMEONE AVAILABLE			NO ONE ABLE TO ASSIST	TOTAL
	FULLY ABLE TO ASSIST	PARTLY ABLE TO ASSIST	NOT AT ALL ABLE TO ASSIST		
Institution to Institution	57 (20) (48)	88 (31) (40)	17 (6) (59)	126 (44) (60)	288 (101)
Community to Institution	30 (27) (25)	56 (50) (25)	5 (5) (17)	20 (18) (9)	111 (100)
Institution to Community	12 (15) (10)	32 (40) (14)	4 (5) (14)	33 (41) (16)	81 (101)
Community to Community	21 (21) (18)	46 (45) (21)	3 (3) (10)	32 (31) (15)	102 (100)
TOTAL	120 (101)	222 (100)	29 (100)	211 (100)	582

* The top ( ) in each square indicates row percentages, and the bottom ( ) indicates column percentages

TABLE 13 - APPLICANTS: Patient Movement (Level of Care Patient was Referred From & Level of Care Patient was Placed in) by Someone to Assist The Applicant in Activities of Daily Living *

PATIENT MOVEMENT	SOMEONE ABLE TO ASSIST APPLICANT IN A.D.L.				
	YES - SOMEONE AVAILABLE			NO ONE ABLE TO ASSIST	TOTAL
	FULLY ABLE TO ASSIST	PARTLY ABLE TO ASSIST	NOT AT ALL ABLE TO ASSIST		
Institution to Institution	65 (20)	98 (30)	18 (6)	143 (44)	324 (100)
Community to Institution	34 (29)	59 (50)	5 (4)	20 (17)	118 (100)
Institution to Community	12 (13)	36 (40)	4 (4)	37 (42)	89 (99)
Community to Community	21 (20)	47 (44)	3 (3)	35 (33)	106 (100)
TOTAL	132	240	30	235	637

* ( ) indicates row percentages

TABLE 14 - PEOPLE: Patient Movement (Level of Care Patient was Referred From & Level of Care Patient was Placed in) by Level of Brain Damage in Patients Referred to A.P.S. *

PATIENT MOVEMENT	BRAIN DAMAGE			TOTAL
	NO DAMAGE	IMPAIRED	SEVERELY IMPAIRED	
Institution to Institution	30 (9) (35)	186 (53) (52)	134 (38) (64)	350 (100)
Community to Institution	16 (14) (19)	59 (53) (17)	37 (33) (18)	112 (100)
Institution to Community	18 (21) (21)	46 (53) (13)	22 (26) (10)	86 (100)
Community to Community	21 (20) (25)	64 (62) (18)	18 (17) (9)	103 (99)
TOTAL	85 (100)	355 (100)	211 (101)	651

* The top ( ) in each square indicates row percentages and the bottom ( ) in each square indicates column percentages

TABLE 15 - APPLICANTS: Patient Movement (Level of Care Patient was Referred From & Level of Care Patient was Placed in) by Level of Brain Damage in Applicants Referred to A.P.S. *

PATIENT MOVEMENT	LEVEL OF BRAIN DAMAGE			TOTAL
	NO DAMAGE	IMPAIRED	SEVERELY IMPAIRED	
Institution to Institution	35 (9)	206 (52)	155 (39)	396 (100)
Community to Institution	17 (14)	64 (53)	40 (33)	121 (100)
Institution to Community	20 (21)	50 (53)	24 (26)	94 (100)
Community to Community	23 (21)	66 (62)	18 (17)	107 (100)
TOTAL	95	386	237	718

* ( ) indicates row percentages

TABLE 16 - PEOPLE: Patient Movement (Level of Care Patient was Referred From & Level of Care Patient was Placed In) by Level of Impairment Functional Capacity (Activities of Daily Living) *

PATIENT MOVEMENT	FUNCTIONAL CAPACITY (A.D.L.)			TOTAL
	NO PROBLEM	IMPAIRED	SEVERELY IMPAIRED	
Institution to Institution	15 (4) (32)	116 (33) (42)	225 (63) (67)	356 (100)
Community to Institution	5 (5) (11)	50 (45) (18)	56 (50) (17)	111 (100)
Institution to Community	9 (10) (19)	51 (59) (19)	26 (30) (8)	86 (99)
Community to Community	18 (17) (38)	58 (55) (21)	30 (28) (9)	106 (100)
TOTAL	47 (100)	275 (100)	337 (101)	659

* The top ( ) in each square indicates the row percentages and the bottom ( ) in each square indicates the column percentages

TABLE 17 - APPLICANTS: Patient Movement (Level of Care Patient was Referred From & Level of Care Patient was Placed In) by Level of Impairment of Functional Capacity (Activities of Daily Living) *

PATIENT MOVEMENT	FUNCTIONAL CAPACITY (A.D.L.)			TOTAL
	NO PROBLEM	IMPAIRED	SEVERELY IMPAIRED	
Institution to Institution	15 (4)	132 (33)	255 (63)	402 (100)
Community to Institution	5 (4)	52 (44)	62 (52)	119 (100)
Institution to Community	10 (11)	55 (59)	29 (31)	94 (101)
Community to Community	19 (17)	60 (55)	31 (28)	110 (100)
TOTAL	49	299	377	725

* ( ) indicates row percentages

It is not surprising that the most severely impaired in A.D.L. and the most severely brain damaged entered institutions, but some did return to the community. Some of these would be considered "unsatisfactory placements" by A.P.S. The effect can be seen on living alone or with someone, and whether there was anyone to give assistance in preventing institutionalization.

Satisfaction with Placement

Table 18 shows A.P.S. satisfaction with the placements and it can be seen that the percentage of those considered unsatisfactory was somewhat higher where placement was in the community. This does not mean A.P.S. is opposed to people remaining in the community but is rather an indication of a lack of adequate community support services.

Utilization of A.P.S. by Hospitals

The ability of A.P.S. to identify the needs of individuals and the services required in the entire district so that the Health Council can plan appropriately will depend on how completely this service is utilized. Graphs 11, 12, 13, 14, (see Appendix) show the number of transfers made from general hospitals to extended care facilities from September 1, 1970 to August 31, 1972, according to the hospital medical records departments; and the number of placements into extended care facilities made by A.P.S. from September 1, 1971 to August 31, 1972 of those patients referred to A.P.S. from those hospitals according to A.P.S. records. The discrepancy is evident and suggests that hospital staffs are still not fully aware of or are reluctant to use A.P.S. for such placements. The discrepancy in the definition of what constitutes an extended care facility is also evident.

TABLE 18: - APPLICANTS: A.P.S.'s SATISFACTION WITH PLACEMENT BY PATIENT MOVEMENT *

PATIENT MOVEMENT	A.P.S. 'S SATISFACTION WITH PLACEMENT	
	SATISFACTORY	UNSATISFACTORY
Institution to Institution	331 (92)	30 (8)
Community to Institution	99 (92)	9 (8)
Institution to Community	60 (85)	11 (15)
Community to Community	51 (88)	7 (12)

* ( ) refers to row percentages

Utilization of A.P.S. by Nursing Care Institutions

Graphs 15, 16, 17, 18 show the admissions to rehabilitation units, chronic hospitals, nursing homes and Homes for the Aged according to their records and the placements in these institutions by the same months according to A.P.S. records. Evidently there are still a number of placements being made in such institutions without A.P.S. involvement, possibly because some institutions feel they can be

more selective (avoiding the "heavier cases") when working independently or because they are pressured by health professionals who want to move a person quickly without waiting to assess his/her total needs. This is influenced by any delays in placement and Table 19 shows the number of people waiting for placement in various institutions at the end of one month at A.P.S. Although the number seems large the rate of turnover is such that most patients do not wait long. Vacancies in standard ward accommodations are rapidly filled, but there may be vacancies in nursing homes at semi-private and private rates for quite long periods.

Staff Education in General Hospitals

Among the major problems identified by A.P.S. is the difficulty health professions have in determining the needs of handicapped people. There is a tendency to focus on immediate needs and short term solutions particularly for people in hospitals. Yet even immediate needs such as the need for sedation, reassurance, or activation may be ignored when the patient appears very "chronic". Patients with fatal conditions sometimes do not seem to have sufficient attention paid to their emotional needs.

Discharge from hospital is often seen as a goal for the patient, whereas it is only a means to a goal which has to be established. Hospital staff may see it as a goal because it will release a bed for hospital care. The A.P.S. form does encourage consideration of these points and is an educative tool as well as a means of helping

TABLE 19: NUMBER OF PEOPLE READY TO BE PLACED BUT AWAITING AN APPROPRIATE VACANCY TO ARISE AS OF SEPT. 29, 1972.

1. Number waiting for Rehabilitation Unit = 1
   males 1, females 0
2. Number waiting for Chronic Hospital = 49
   males 23, females 26
3. Number waiting for Nursing Homes = 90*
   Extended care =25 males 6, females 19
   Intermediate = 1 males 0, females 1
   don't know =64
4. Number waiting for Homes for the Aged = 58
   normal care =44 males 14, females 30
   bed care = 2 males 0, females 2
   special care =12 males 5, females 7
5. Number waiting for Lodging Houses = 8
   males 4, females 4
6. Number waiting for Other Facilities = 14
   Specify: assessment by Cerebral Palsy Centre = 1
   Day Therapy Centre (St. Peter's) =13

TOTAL NUMBER WAITING FOR VACANCIES = 220

* A significant number of these were awaiting the opening of a new nursing home in the area.

an individual patient. The A.P.S. form requires completion by several health professionals and so encourages communication between them. However, lack of consistency in response in the form indicates that there is still a problem of poor communication within the health team.

Early Application to A.P.S.

Although hospital staff wish speedy action after sending in an application they tend to delay sending the assessment form until they have decided on discharge. This is rather late to start planning arrangements for on-going management. A.P.S. would prefer that on admission, or before it, the physician should identify expected duration of hospital stay and refer any patient likely to remain over 30 days or to need on-going care. Even if the physician believes he knows the services needed, it would enable A.P.S. to estimate the total load on various health services.

Lack of Understanding of Roles of Health Facilities

There seems to be no clear understanding by many health professionals of the aims and purposes of other health facilities. The role of rehabilitation units, chronic hospitals, nursing homes, Homes for the Aged, Home Care, and psychiatric services is poorly understood and so unreasonable demands are put upon them and they may be misused. A.P.S. staff has given talks and information on many occasions to health personnel in these institutions, in general hospitals and in the community.

In the past health institutions have had considerable freedom in determining their own roles and have not always responded to the needs of people in the society they serve. With the information A.P.S. collects on needs and present programs it will be possible for the Health Council to request an institution to modify its role to meet the need for new or different approaches.

Information Transfer to Long Stay Institutions

Transfer of information between health institutions has been poor in some cases. Nursing homes in particular have often not received enough information to know if they could manage a person's problems or not. It has been expected that the personal physician would inform nursing home staff about the person's needs but his notes and comments are often cryptic. By means of the A.P.S. assessment form it is possible to inform the receiving institution fully, prior to placement, so that appropriate management can be ensured. Placement without using A.P.S. prevents this information transfer and this is still a problem.

Understandably some nursing care institutions try to select only the patients who have fewer requirements and A.P.S. attempts to ensure a fair distribution of more demanding cases ("heavier" cases) provided the person's treatment needs can be met and placement is appropriate on the basis of language, culture and proximity of relatives.

Extended Health Care Legislation and Nursing Homes

The introduction of the Extended Health Care Benefit program provided a more secure financial basis for treatment of people needing nursing care. The higher space and staff requirements have posed problems for various nursing homes and some have decided to close. This has thrown an additional load on A.P.S. to find alternate accommodation. Some of the smaller homes have a more homely and less institutional atmosphere and it is hoped they will be able to continue functioning

and to meet the higher standards. Prior to the new legislation, the A.P.S. and the Extended Care Committee were involved in the preparation of a Brief to the Provincial Government on Nursing Care Institutions which was approved by the Health Council. A point made in that brief was that although physiotherapy and other services should be available to persons in nursing homes, some mechanism must be set up to prevent overuse of such services. Perhaps the Home Care program or other local organizations could set up criteria of use and supervise the provision of service.

Extended Health Care Form

The A.P.S. was consulted when the Eligibility form for the Extended Health Care Benefit was designed. However, the form does not elicit as much information as the A.P.S. assessment form because it only attempts to determine eligibility for coverage, not total care needs. The A.P.S. form therefore should not be dispensed with but utilized first and, if it shows the need for nursing care then the Extended Care form could be completed. There are several problems to be met:

(1) because it requires about two weeks to receive a reply on eligibility, health professionals tend to send in the Extended Care form in any case even if the person may not require long term nursing care, and

(2) if the Extended Care form were sent in only after A.P.S. has shown a need for nursing care there could be a delay.

Understandably nursing homes are reluctant to accept a patient whose eligibility is not settled. If A.P.S. were responsible for identifying need and involved in completing the Extended Care form it would speed the process and would also encourage more accuracy in the completion of the Extended Care form.

Nursing Homes & A.P.S.

Most of the nursing homes have cooperated enthusiastically with A.P.S. and feel they have benefited in understanding better the needs of their patients and in improved communication with other health institutions. The local association has become more active and has acted as a liaison with the A.P.S. When complaints are received by A.P.S. about a nursing home, the A.P.S. staff convey the complaint to the Home Administrator or the local association with suggestions, if appropriate. The appointment by the Ministry of Health of a regional Nursing Home consultant will provide for further improvement in the standards of nursing homes and A.P.S. will work closely with her.

Activation in Nursing Homes

An important need of residents of nursing homes is for activation and recreation. The new Nursing Home legislation requires that programs be established and during the summer of 1972, A.P.S. employed two graduates in Physical Education to study the problems nursing homes have in providing activation. The two consultants organized some activities, identified where activities and advice could be obtained by nursing homes, and studied what problems arose when programs were tried. They organized a workshop on activation attended by nursing home operators and staffs, and the "Proceedings of the Workshop", which contains specific information and advice, is available from A.P.S. Their "Final Report" with recommendations is also available from A.P.S. and contains many practical suggestions of value to anyone involved in the provision of long term nursing care. The A.P.S. and the Extended Care Committee will develop these recommendations and encourage nursing home operators to act on them.

Lacks in Community Health Services

Community health services are inadequate at present to support many handicapped persons at home. The Home Care program cannot answer long-term needs unless the legislation governing it is altered. Home nursing and Homemaker services are available at a charge which can be excessive for the person with on-going needs. Residential supervised accommodation is not available except in "Special Care Homes" for people leaving the psychiatric hospital. Consideration therefore should be given to expanding Home Care to provide for on-going needs and to coordinate special programs, such as supervision of persons with a chronic respiratory handicap, within it. A number of supervised auxiliary homes ("foster homes") are needed where a person can maintain a large degree of independence but where any breakdown in health or function can be identified early. Medication may also have to be supervised to be sure they are taken and that any undesirable side effects are noted.

Need for Follow-up

The follow-up of all people one month after placement has not been carried out as planned by A.P.S. staff, due to pressure of work. In some cases Public Health Nurses have been asked to do so and their reports have been excellent. Consideration should be given to expanding the follow-up by public health nurses and to developing a protocol and feed-back mechanism to enable persons with all types of disability and handicaps to be followed-up at appropriate intervals.

Special Program for Children & Young Adults

St. Peter's Hospital is developing into a Geriatric Centre that provides "chronic hospital" level of care and an outreach Day Therapy program. The plan for a Home for the Aged nursing care section was shelved when A.P.S. showed that there were vacancies in the existing Homes for the Aged, and because the nursing home industry's response to the Extended Care program was not yet clear. The continued presence of children in St. Peter's was inappropriate and, with the approval of the Committee on Extended Care and the Hamilton District Health Council, it was agreed that Chedoke Hospitals would assume responsibility for long term care of children, young adults and adults up to the Geriatric category — particularly at the Brow Infirmary where program revisions are under way. It is recognized that the physical facilities are inadequate and recommendations have been submitted to the Planning Committee of Council.

Spinal Cord Injury Problems

People with spinal cord injury have special needs also. Frequently they are young and may have severe handicap due to paralysis of the legs (paraplegia) or of arms and legs (quadriplegia). With modern rehabilitation most paraplegics can return to community living but quadriplegics require help with activities of daily living because of the weakness of arms as well as legs. This should not require them to live in a nursing care institution provided they can obtain some nursing help each day elsewhere. They require a vigorous program to prepare them mentally and physically for the rigours of trying to live as normal a life as possible. At present a special program is being developed at the Brow "chronic" hospital but ultimately it should be possible to develop a special hostel with employment opportunities.

Final Comment

The aims and purposes of the Assessment and Placement Service of the Hamilton District Health Council has been reviewed along with a statistical analysis of its function and comments. Problems and lacks in services have been identified and some remedial action has been initiated or recommended. It is unlikely the A.P.S. can reduce costs of health services although it should improve efficiency and effectiveness and hopefully will increase the services available to the handicapped. Expenditures on health needs of chronically disabled and handicapped people have been small up to the present and attempts to reduce costs of their expense could hardly be recommended or justified.

Appendix

TABLE 20 - SEX OF APPLICANTS TO A.P.S. BY AGE *

AGE	SEX		TOTAL
	MALE	FEMALE	
0 - 19	10 (2)	5 (1)	15
20 - 29	19 (3)	7 (1)	26
30 - 39	16 (3)	9 (1)	25
40 - 49	35 (6)	23 (3)	58
50 - 59	51 (9)	49 (6)	100
60 - 69	93 (16)	111 (13)	204
70 - 79	162 (28)	256 (30)	418
80 - 89	154 (27)	342 (40)	496
90 - 99	36 (6)	61 (7)	97
100 +	0 (0)	2 (0)	2
TOTAL	576 (100)	865 (102)	1441

* ( ) indicates column percentages

TABLE 21 - MARITAL STATUS OF APPLICANTS BY AGE *

AGE	MARITAL STATUS						TOTAL
	MARRIED	SINGLE	DIV.	SEP.	WIDOWED	OTHER	
0 - 19	0 (0)	9 (90)	1 (10)	0 (0)	0 (0)	0 (0)	10 (100)
20 - 29	1 (5)	20 (91)	0 (0)	1 (5)	0 (0)	0 (0)	22 (101)
30 - 39	6 (26)	12 (52)	3 (13)	2 (9)	0 (0)	0 (0)	23 (100)
40 - 49	17 (33)	17 (33)	4 (8)	10 (20)	3 (6)	0 (0)	51 (100)
50 - 59	32 (36)	24 (27)	7 (8)	15 (17)	10 (11)	0 (0)	88 (99)
60 - 69	56 (32)	31 (18)	6 (3)	25 (14)	56 (32)	2 (1)	174 (99)
70 - 79	102 (28)	46 (12)	2 (1)	26 (7)	192 (52)	0 (0)	370 (101)
80 - 89	83 (20)	34 (8)	1 (0)	9 (2)	288 (69)	0 (0)	415 (99)
90 - 99	7 (9)	9 (12)	0 (0)	0 (0)	58 (78)	0 (0)	74 (99)
100 +	0 (0)	0 (0)	0 (0)	0 (0)	2 (100)	0 (0)	2 (100)
TOTAL	304	202	24	88	609	2	1229

* ( ) indicates row percentages

TABLE 22 - WHO THE APPLICANT WAS LIVING WITH AT ONSET OF PRESENT EPISODE BY AGE *

AGE	APPLICANT LIVING WITH:									TOTAL
	ALONE	SPOUSE	CHILDREN	SPOUSE & CHILDREN	RELAT-IVES	COMPAN-ION	INSTITUT-ION	OTHER	DON'T KNOW	
0 - 19	1 (9)	0 (0)	0 (0)	0 (0)	6 (55)	0 (0)	3 (27)	1 (9)	0 (0)	11 (100)
20 - 29	2 (9)	0 (0)	0 (0)	1 (4)	16 (70)	1 (4)	2 (9)	1 (4)	0 (0)	23 (100)
30 - 39	7 (29)	1 (4)	0 (0)	6 (25)	7 (29)	0 (0)	1 (4)	2 (8)	0 (0)	24 (99)
40 - 49	9 (16)	6 (11)	5 (9)	11 (20)	9 (16)	1 (2)	8 (15)	6 (11)	0 (0)	55 (100)
50 - 59	30 (34)	17 (19)	3 (3)	12 (13)	14 (16)	0 (0)	9 (10)	4 (4)	0 (0)	89 (99)
60 - 69	65 (36)	38 (21)	13 (7)	7 (4)	13 (7)	1 (1)	27 (15)	13 (7)	3 (2)	180 (100)
70 - 79	114 (30)	81 (21)	75 (20)	12 (3)	22 (6)	12 (3)	43 (11)	12 (3)	7 (2)	378 (99)
80 - 89	115 (26)	62 (14)	101 (23)	11 (3)	42 (10)	8 (2)	79 (18)	20 (5)	2 (0)	440 (101)
90 - 99	15 (19)	2 (3)	27 (35)	3 (4)	8 (10)	3 (4)	16 (21)	1 (1)	3 (4)	78 (101)
100 +	0 (0)	0 (0)	1 (50)	0 (0)	0 (0)	0 (0)	0 (0)	1 (50)	0 (0)	2 (100)
TOTAL	358	207	225	63	137	26	188	61	15	1280

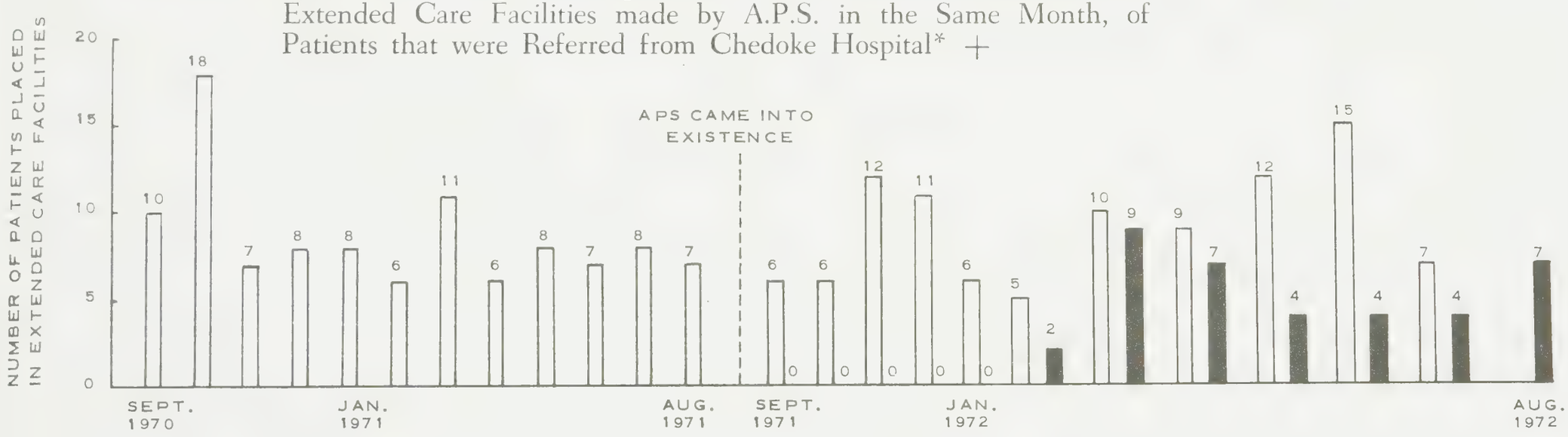
* ( ) indicates row percentages

TABLE 23 - SEX OF APPLICANTS BY MARITAL STATUS *

MARITAL STATUS	SEX		TOTAL
	MALE	FEMALE	
Married	178 (35)	127 (17)	305
Single	113 (22)	89 (12)	202
Divorced	12 (2)	12 (2)	24
Separated	54 (11)	34 (5)	88
Widowed	145 (29)	467 (64)	612
Other	0 (0)	2 (0)	2
Don't Know	1 (0)	1 (0)	2
TOTAL	503 (99)	732 (100)	1235

* indicates column percentages

GRAPH 11 Chedoke Hospital: Number of Discharges to Extended Care Facilities by Chedoke Hospital Compared to the Number of Placements into Extended Care Facilities made by A.P.S. in the Same Month, of Patients that were Referred from Chedoke Hospital* +



SEPTEMBER 1970 TO AUGUST 1972

* (A) Definition of
"Extended Care Facility":

a) for Chedoke Hospital: Mental Hospitals (long term wards), Convalescent Hospitals (Rehab Units), Chronic Hospitals, Nursing Homes, Homes for the Aged, Rest Homes

b) for A.P.S.: Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged, (Rest Homes — none exist in the Hamilton District)

(B) Total Number of Discharges (including Deaths) from Chedoke Hospital (a 219 bed acute treatment hospital):
Sept. 1970 - Aug. 1971 = 6724
Sept. 1971 - Aug. 1972 — 6794

\+ Hospital data was not available for August 1972

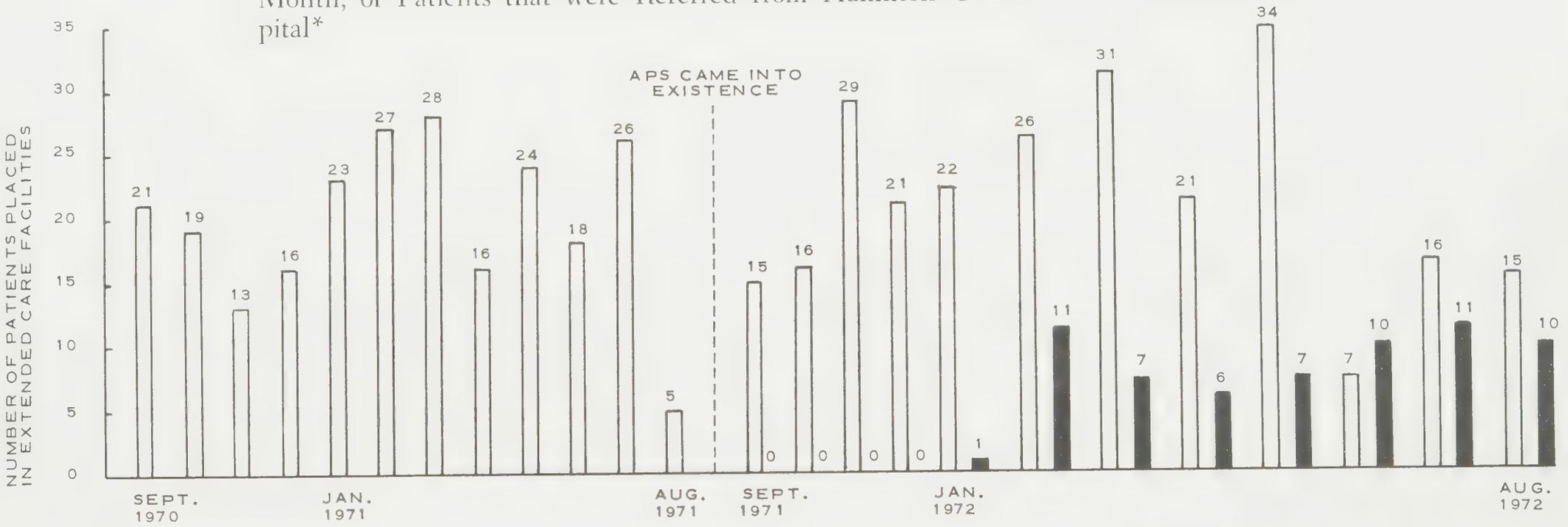
LEGEND

Hospital Discharges . . . Totals:
Sept. 1970 - Aug. 1971 = 104
Sept. 1971 - July 1972 = 99

A.P.S. Placements . . . Total:
Sept. 1971 - Aug. 1972 = 37

GRAPH 12 Hamilton General Hospital: Number of Discharges to Extended Care Facilities By Hamilton General Hospital Compared to the Number of Placements into Extended Care Facilities made by A.P.S. in the Same Month, of Patients that were Referred from Hamilton General Hospital*

September 1970 to August 1971



* (A) Definition of "Extended Care Facility":

a) for Hamilton General Hospital: Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged (excludes Mental Hospitals)

b) for A.P.S.: Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged, (Rest Homes — none exist in the Hamilton District)

(B) Total Number of Discharges (including Deaths) from Hamilton General Hospital (a 569 bed acute treatment hospital):
September 1970 - August 1971 = 13,280
September 1971 - August 1972 = 14,935

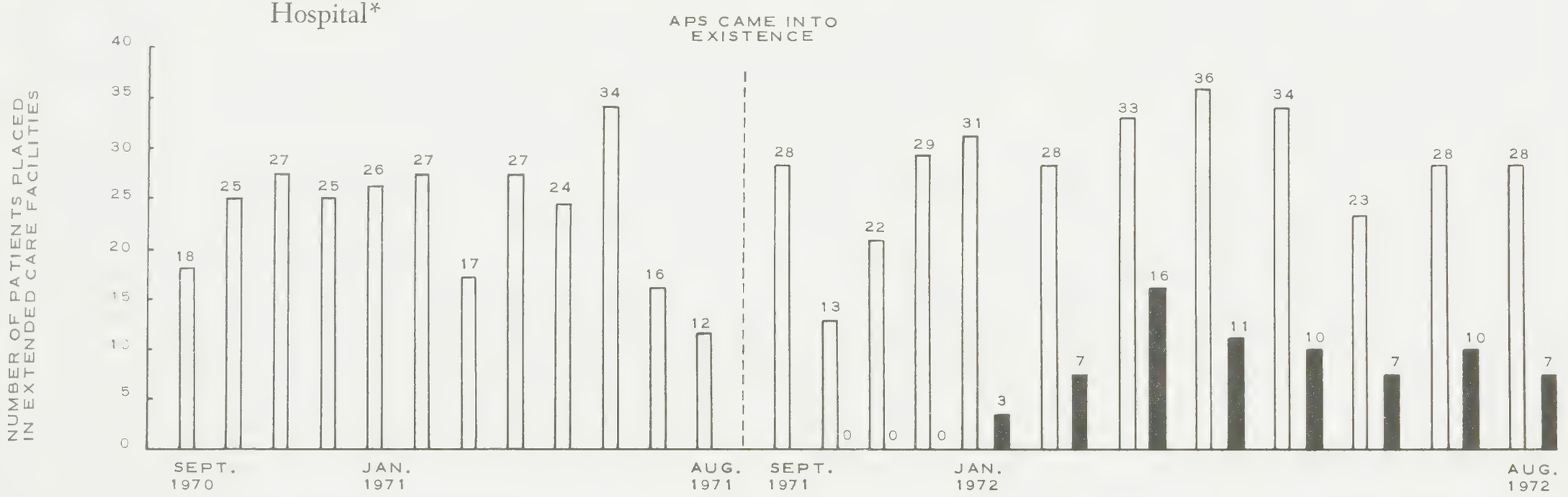
LEGEND

Hospital Discharges . . . Totals:
Sept. 1970 - Aug. 1971 = 236
Sept. 1971 - Aug. 1972 = 253

A.P.S. Placements . . . Total:
Sept. 1971 - Aug. 1972 = 63

GRAPH 13 Henderson General Hospital: Number of Discharges to Extended Care Facilities by Henderson General Hospital Compared to the Number of Placements into Extended Care Facilities made by A.P.S. in the Same Month, of Patients that were Referred from Henderson General Hospital*

September 1970 to August 1972



*Definition of "Extended Care Facility":

a) for Henderson General Hospital: Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged (excludes Mental Hospitals)

b) for A.P.S.: Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged, (Rest Homes — none exist in the Hamilton District)

(B) Total Number of Discharges (including Deaths) from Henderson General Hospital (a 621 bed acute treatment hospital)

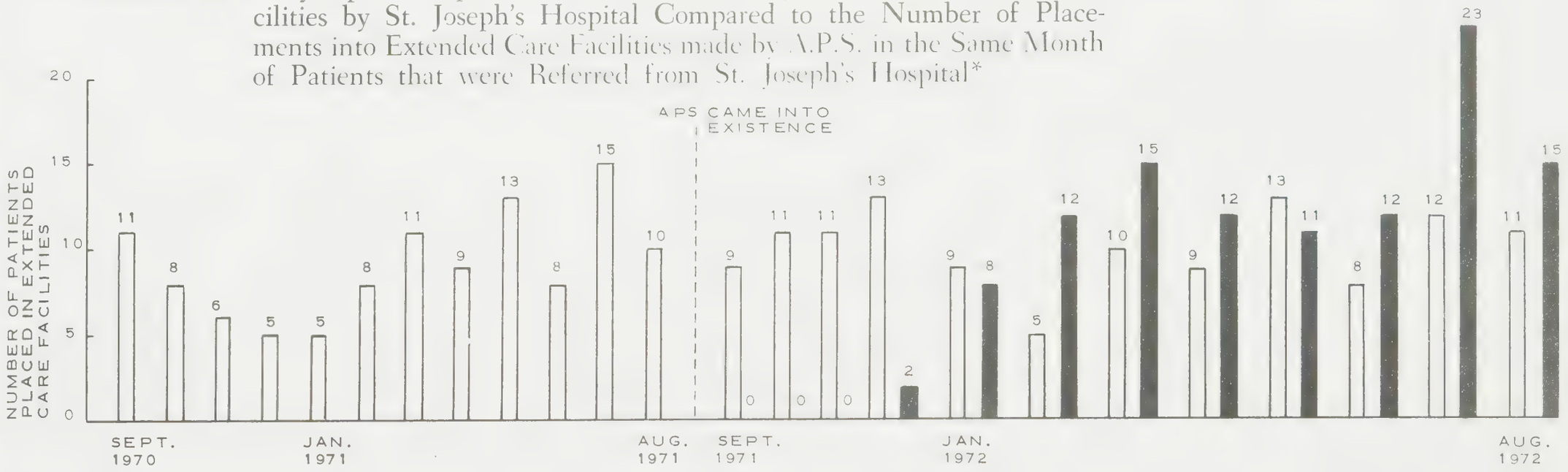
September 1970 - August 1971 = 23,016
September 1971 - August 1972 = 23,744

LEGEND

Hospital Discharges . . . Totals:
Sept. 1970 - Aug. 1971 = 278
Sept. 1971 - Aug. 1972 = 333

A.P.S. Placements . . . Total:
Sept. 1971 - Aug. 1972 = 71

GRAPH 14 St. Joseph's Hospital: Number of Discharges to Extended Care Facilities by St. Joseph's Hospital Compared to the Number of Placements into Extended Care Facilities made by A.P.S. in the Same Month of Patients that were Referred from St. Joseph's Hospital*



September 1970 to
August 1972

LEGEND

Hospital Discharges . . . Totals:
Sept. 1970 - Aug. 1971 = 109
Sept. 1971 - Aug. 1972 = 121

A.P.S. Placements . . . Total:
Sept. 1971 - Aug. 1972 = 110

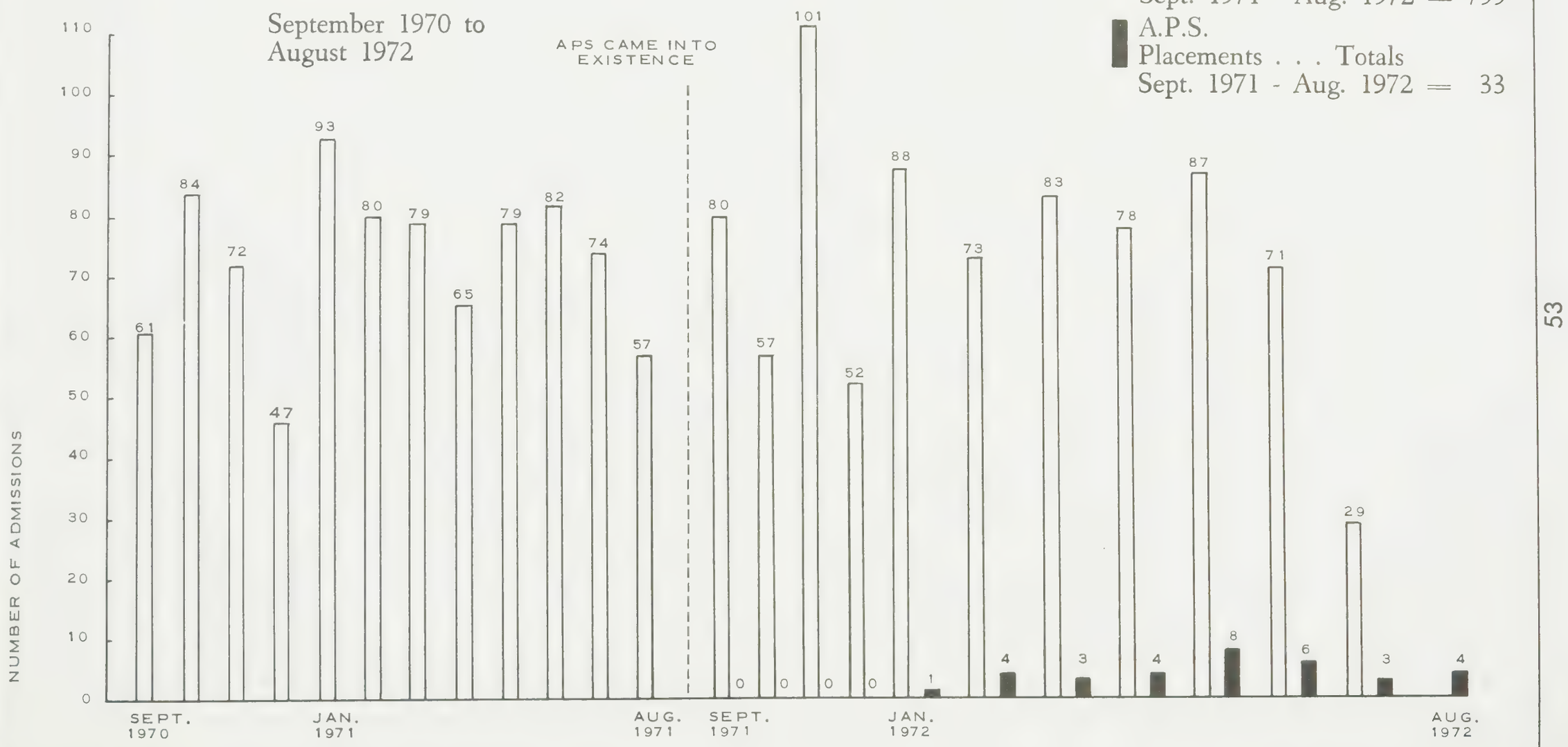
* (A) Definition of "Extended Care Facility":

a) For St. Joseph's Hospital: Nursing Homes, Homes for the Aged (excludes mental hospitals, chronic hospitals and rehabilitation units)

b) for A.P.S.: Mental Hospitals, Rehabilitation Units, Chronic Hospitals, Nursing Homes, Homes for the Aged, (Rest Homes — none exist in the Hamilton District)

(B) Total Number of Discharges (including Deaths) from St. Joseph's Hospital (a 713 bed acute treatment hospital)
September 1970 - August 1971 = 31,764
September 1971 - August 1972 = 31,980

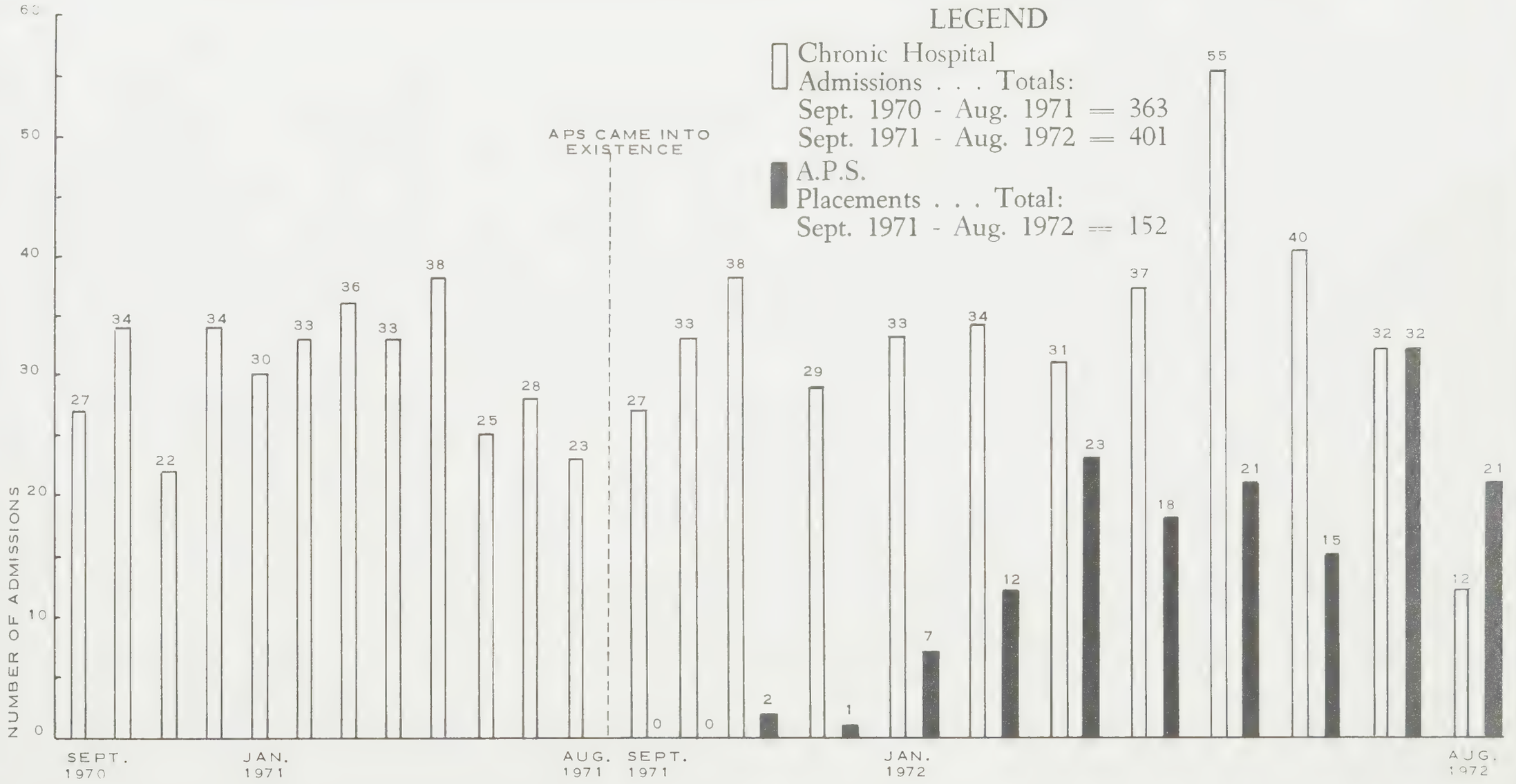
GRAPH 15 Rehabilitation Units: Number of Admissions to all Rehabilitation Units in the District Compared to the Number of Placements into Rehabilitation Units made by A.P.S. in the Same Month*



* incomplete information from Rehab Facilities after June 1972

GRAPH 16 Chronic Hospitals: Number of Admissions to All Chronic Hospitals in the District Compared to the Number of Placements into Chronic Hospitals made by A.P.S. in the Same Month*

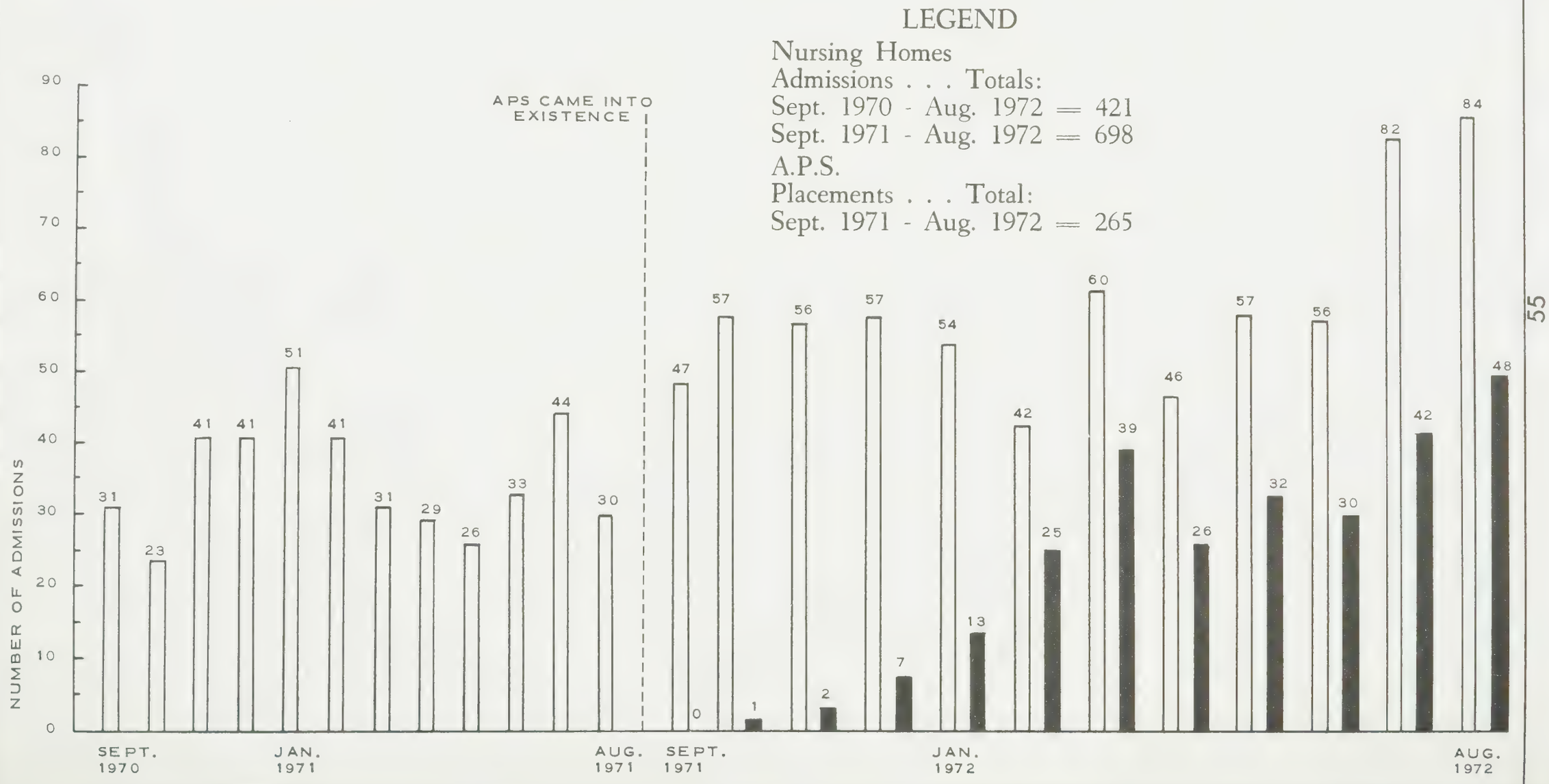
September 1970 to August 1972



* incomplete information from Chronic Hospitals After June 1972

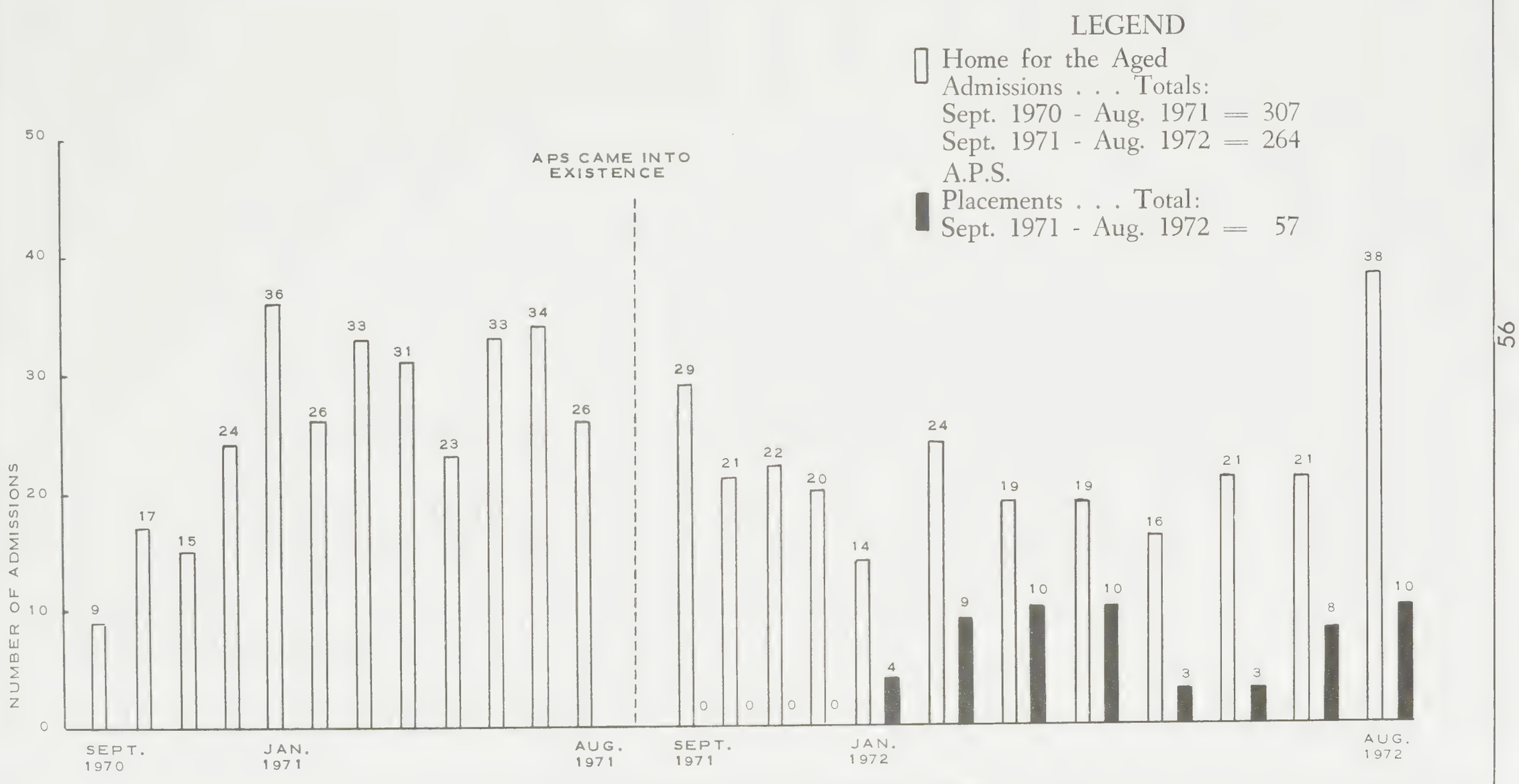
GRAPH 17 Nursing Homes: Number of Admissions to all Nursing Homes in the District Compared to the Number of Placements into Nursing Homes made by A.P.S. in the Same Month

September 1970 to August 1972



GRAPH 18 Homes for the Aged: Number of Admissions to All Homes for the Aged in the District Compared to the Number of Placements into Homes for the Aged by A.P.S. in the Same Month

September 1970 to August 1972



1. Patient's Identification Number: [ ][ ][ ][ ][ ][ ] (2 3 4 5 6 7)

2. Referral Form Number:
(number of times referral process has been initiated) (NA=99) [ ][ ] (8 9)

3. Date of Contact with A.P.S.
(date referral process initiated)
(NA=99) [ ][ ][ ] Mo. Day Yr.
10/11/12/13/14/15/

4. Person who made first contact with A.P.S.
(i.e. person initiating referral process)

1) — Family physician ..... = 01 ☐
2) — Non-family physician ..... = 02 ☐
3) — Patient (self) ..... = 03 ☐
4) — Relative of patient ..... = 04 ☐
5) — Friend of patient ..... = 05 ☐
6) — Public health nurse ..... = 06 ☐
7) — Home care (V.O.N., Visiting Homemaker, etc.) ..... = 07 ☐
8) — Community social service agency ..... = 08 ☐
9) — Non-physician in acute care hospital ..... = 09 ☐
10) — Non-physician in an extended care facility (i.e. chronic hospital, rehab. unit, nursing home, home for aged, lodging house, psychiatric hosp.) ..... = 10 ☐
11) — Other — specify ..... = 11 ☐
12) — DK (Don't know) ..... = 88 ☐
13) — NA (Not answered) ..... = 99 ☐
16/17/

5. Type of Service

1) — Referral — No Contact (minimal information on patient — have not been asked to initiate referral) ..... ☐ = 1
2) — Brief Service ("Contact sheet" and/or letter only) ..... ☐ = 2
3) — "Partial" Assessment (either physician or social-nursing section of Referral Form not completed) ..... ☐ = 3
4) — Complete Assessment (Referral Form complete) ..... ☐ = 4
18/

6. Date of Placement: (see "Follow-up Sheet")

(NA=99) Mo. Day Yr. 19/20/21/22/23/24/

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7. Number of days between first contact (qu. 3) and the date when this Referral Form (both sections) was received back by A.P.S. (receiving date stamp, if present): (NA=999) ☐☐☐ 25 26 27

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8. Number of days between date when both sections of Referral Form received back by A.P.S. (receiving date stamp, if present) and date of first recommendation made by A.P.S. (NA=999) ☐☐☐ 28 29 30

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9. Number of days between date of first recommendation made by A.P.S. and date of actual placement: (NA=999) ☐☐☐ 31 32 33

---

10. Patient Died:
1. — Before being placed — no specific time ..... = 1 ☐
2. — Before being placed — after initial contact, but before receipt of completed Referral Form (see question 7) ..... = 2 ☐
3. — Before being placed — after receipt of completed Referral Form, but before first recommendations were made (see question 8) ..... = 3 ☐
4. — Before being placed — after first recommendations were made, but before placement (see question 9) ..... = 4 ☐
5. — After being placed ..... = 5 ☐
6. — N.A. ..... = 9 ☐

34/

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11. Additional Information required after A.P.S. received both social-nursing and medical sections of Referral Form:
1) — Yes = 1 ☐
2) — No ..... = 2 ☐
3) — DK ..... = 8 ☐
4) — NA ..... = 9 ☐

35/

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12. Location (Level of care) of first placement recommendation step (final recommendation) made by A.P.S. : (see Health Care Facility code list) ☐☐ 36 37

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13. Patient has been accepted by Extended Care Program:
1) — Yes ..... = 1 ☐
2) — No ..... = 2 ☐
3) — NA ..... = 9 ☐

38/

14. Location (Level of Care) of patient's Actual Placement :
(see Health Care Facility code list) ☐☐ 39 40

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15. Satisfaction with Actual Placement (see Follow-up Sheet):
(see separate open-ended code list and record problems and reasons — other than those that are listed) ☐☐ 41 42

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16. Location (Level of Care) of patient when referred to A.P.S.
(see Health Care Facility code list) ☐☐ 43 44

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17. Sex of Patient :

1) — Male = 1 ☐
2) — Female = 2 ☐
3) — NA = 9 ☐ 45/

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18. Religion of Patient :

1) — Roman Catholic = 1 ☐
2) — Protestant = 2 ☐
3) — Jewish = 3 ☐
4) — No Religion = 4 ☐
5) — Other = 5 ☐
6) — NA = 9 ☐ 46/

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19. Marital Status :

1) — Married = 1 ☐
2) — Single = 2 ☐
3) — Divorced = 3 ☐
4) — Separated = 4 ☐
5) — Widowed = 5 ☐
6) — Other = 6 ☐
7) — DK = 8 ☐
8) — NA = 9 ☐ 47/

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20. Age :
(see Age Conversion Table and Date of Birth from Referral Form)
(NA=999) ☐☐☐ 48 49 50

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21. Patient's Next of Kin:

1) — At least one identified = 1 ☐
2) — No one identified = 2 ☐
3) — NA = 9 ☐ 51/

22. Languages Understood by Patient :

1) — Understands English ..... = 1 ☐
2) — Unable to understand English .. = 2 ☐
3) — NA ..... = 9 ☐ 52/

---

23. Other languages than English understood by Patient:
(code primary if more than one "other" language recorded)

Language other than English :
(i.e. first one recorded)

1) — Italian ..... = 1 ☐
2) — German ..... = 2 ☐
3) — French ..... = 3 ☐
4) — Polish ..... = 4 ☐
5) — Other — Specify ..... = 5 ☐
6) — NA ..... = 9 ☐ 53/

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24. Employment :
(binary coding)

1) — Employed — full-time ..... = 1 ☐
2) — Employed — part-time ..... = 2 ☐
3) — Unemployed ..... = 4 ☐
4) — Retired ..... = 8 ☐
5) — Never Worked ..... = 16 ☐
6) — Student ..... = 32 ☐
7) — Housewife ..... = 64 ☐
8) — DK ..... = 888 ☐
9) — NA ..... = 999 ☐

☐☐☐ 54 55 56

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25. Income :

1) — None ..... = 1 ☐
2) — Under $100 per month ..... = 2 ☐
3) — $100 - $200 per month ..... = 3 ☐
4) — $200 - $400 per month ..... = 4 ☐
5) — Over $400 per month ..... = 5 ☐
6) — DK ..... = 8 ☐
7) — NA ..... = 9 ☐ 57/

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26. Source of Financial Support :
(binary coding)

1) — Private ..... = 1 ☐
2) — Family ..... = 2 ☐
3) — Other ..... = 4 ☐
4) — DK ..... = 8 ☐
5) — NA ..... = 9 ☐

☐ 58

27. With Whom Living at Onset of Present Episode:

1) — Alone = 01 ☐
2) — With Spouse = 02 ☐
3) — With Children = 03 ☐
4) — With Spouse & Children = 04 ☐
5) — With Other Relatives = 05 ☐
6) — With Companion = 06 ☐
7) — In Institution = 07 ☐
8) — Other = 08 ☐
9) — DK = 88 ☐
10) — NA = 99 ☐ 59/60/

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28. Is there anybody able to assist the applicant in the activities of daily living:

1) — Yes — fully = 1 ☐
2) — Yes — partially = 2 ☐
3) — Yes — not at all = 3 ☐
4) — No = 4 ☐
5) — DK = 8 ☐
6) — NA = 9 ☐ 61/

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29. Brain Damage:

(see page 4, questions 1 & 2)

1) No Brain Damage:
("normal" category 1, but nothing greater, marked for questions 1 and 2) = 1 ☐
2) Impaired:
(category 2 or 3, but nothing greater, marked for questions 1 or 2) = 2 ☐
3) Severely Impaired:
(category 4 or 5, marked for questions 1 or 2 = 3 ☐
4) NA = 9 ☐ 62/

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30. Mood and Behaviour:

(see page 4, questions 3, parts a,b,c,d,e and f)

1) No Functional Psychological Impairment:
(categories 1,2, or 3 but nothing greater, marked on questions 3 "a" to "f") = 1 ☐
2) Functional Psychological Impairment:
(categories 4 or 5 marked on any one of 3 "a" to "f" = 2 ☐
3) NA = 9 ☐ 63/

---

31. Patient needs Indwelling Catheter:

1) — Yes = 1 ☐
2) — No = 2 ☐
3) — NA = 9 ☐ 64/

32. Activities of Daily Living:
(all of page 6 of Referral Form, except 1 & 2 of "Communication" — also includes "Ambulation" page 7)

1) No Problems with A.D.L.
(only A's marked in all questions) = 1 ☐
2) Impaired:
(B or C marked on any one of the questions, but nothing greater) ..... = 2 ☐
3) Severely Impaired:
(D or E marked on any one of the questions) ..... = 3 ☐
4) NA ..... = 9 ☐ 65/

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33. Position of Person Completing Social-Nursing Section of Referral Form (binary coding)

1) — Family Physician = 1 ☐
2) — Non-family Physician ..... = 2 ☐
3) — Social Worker = 4 ☐
4) — Public Health Nurse ..... = 8 ☐
5) — Other health professional —
Specify ..... = 16 ☐
6) — DK ..... = 88 ☐
7) — NA ..... = 99 ☐

☐☐ 66 67

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34. Family Physician, or Responsible Physician:
(See Canadian Medical Directory List)
Specify: .....
(DK=888) (NA=999)

☐☐☐ 68 69 70

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35. Diagnosis:
(See Medical Coding Sheet — adaptation of I.C.D.A.)

A) Primary Diagnosis::
Specify .....

☐☐ 72 72

B) Secondary Diagnosis:
Specify

☐☐ 73 74

HEALTH CARE FACILITY CODE LIST

Code for Questions 12,14,16: Level Recommended, Level Placed, Level Referred From

Facility	Code
1) — Chedoke Hospitals (includes Mountain San.)	01
2) — Hamilton General	02
3) — Henderson General	03
4) — St. Joseph's	04
5) — Joseph Brant	05
6) — Other hospital	06
7) — Psychiatric Hospital or unit: acute care	07
8) — Psychiatric Hospital or unit: extended care (includes Homes for Mentally Retarded, e.g. Cedar Springs)	08
9) — Special Rehab. Unit	09
10) — General Rehab. Unit (includes Joseph Brant Chronic, if a rehab. case)	10
11) — Chronic Hospital	11
12) — Nursing Home (includes Homes for Special Care Nursing homes)	12
13) — Home For The Aged: bed care	13
14) — Home For The Aged: special care	14
15) — Home For The Aged: normal care	15
16) — Lodging Houses	16
17) — Special Living Facilities	17
18) — Support Services	18
19) — Other (i.e. Day Centres, Home for Special Care Residential Homes, Community Psychiatric Teams, etc.)	19
20) — Home	20
21) — Don't Know	88
22) — Not Answered	99

"SATISFACTION WITH ACTUAL PLACEMENT"

Code List: Code for Question 15

Generally Satisfactory:	Code
1) — Generally Satisfactory	01
2) — Generally Satisfactory — But a Problem in making placement — (list)	02
3) — Generally Satisfactory — with 1st, 2nd, etc. placements	03
4) — Generally Satisfactory — with 1st — but unsatisfied with 2nd, etc. placements	04
Generally Unsatisfactory:	
5) — Generally Unsatisfactory — Unspecific	05
6) — Generally Unsatisfactory — Refuses to accept recommended placement	06
7) — Generally Unsatisfactory — No facility exists to meet patient's needs adequately	07
8) — Generally Unsatisfactory — Other reasons (list)	08
9) — Generally Unsatisfactory — A problem in making placement — (list)	09
10) — Generally Unsatisfactory — With 1st, 2nd, etc. placements	10

11) — Generally Unsatisfactory — With 1st, but satisfied with 2nd, etc. placements 11
12) — Don't know 88
13) — Not Answered 99

SPECIAL NOTE:
If no follow-up sheet is present, but person was placed, satisfaction is to be coded as Don't Know.

PRIMARY AND SECONDARY DIAGNOSES

Medical Coding Question 35

Code	Diagnosis
01	Infectious and Parasitic (Except TB and late effects of Polio)
02	Tuberculosis
03	Late Effects of Polio
04	Neoplasms: (Buccal and Pharynx)
05	Digestive
06	Respiratory
07	Bone, Skin, Breast
08	G-U
09	Other sites
10	Lymphatic & Haemopoietic
11	Benign
12	Unspecified
13	Thyroid Disorders
14	Other Endocrine (except Thyroid and Diabetes Mellitus)
15	Diabetes Mellitus
16	Nutritional Deficiencies (incl. obesity)
17	Other Metabolic
18	Disease Blood
19	Senile and Pre Senile Dementia
20	Alcoholic Psychosis
21	Psychosis other cerebral condition (arteriosclerois and other brain damage)
22	Psychosis . . . non cerebral physical condition
23	Schizophrenia
24	Affective Psychosis
25	Paranoid Psychosis
26	Other psychoses
27	Neuroses (Anxiety and Depression)
28	Personality disorders
29	Alcoholism
30	Other drug dependence
31	Other non psychotic Mental Disorders
32	Mental Retardation
33	Diseases of Nervous System (incl. hemiplegia, paraplegia non vascular non traumatic)
34	Multiple Sclerosis
35	Parkinsonism
36	Cerebral spastic infantile paralysis

37 Epilepsy
38 Motor Neurone Disease
39 Diseases of Peripheral Nerves
40 Eye Condition (all types)
41 Ear Condition (all types)
42 Rheumatic Heart Disease
43 Hypertensive Disease (including heart and kidney disorder)
44 Ischaemic Heart Disease
45 Other Heart Diseases
46 Cerebrovascular Disorder (including subarachnoid haem.)
47 Disease Arteries Veins Lymphatics
48 Respiratory Diseases
49 Digestive Tract excl. liver
50 Disease liver, gall bladder and bile ducts
51 Diseases GU (non neoplastic)
52 Diseases of skin
53 Arthritis Rheumatism all Musculo Skeletal Disorders
54 Congenital
55 Senility without psychosis
56 Fracture skull spine and trunk
57 Fracture Upper limb
58 Fracture Lower limb
59 Other injuries and accidents
60 Traumatic Paraplegia and Quadriplegia

DEFINITION OF SPECIAL TERMS

APPLICANT

A person may make several applications to A.P.S. for assessment resulting in several assessment forms, or partial assessments being completed on the same person at different points in time. The term "applicant" indicates that each application to A.P.S. (whether for information only, a partial or a complete assessment) is included in the analysis, even though there may be several assessments on the same person.

PEOPLE

The term "people" indicates that only the first application from any particular individual is included in the analysis.

PATIENT MOVEMENT

This term indicates the movement of an individual, according to A.P.S. statistics, from the level of care that the person was referred from (institution or community) to the level of care that the person was placed in.

INSTITUTION

For the purpose of this report, "institution" includes the following health care facilities or levels of care: acute hospitals, psychiatric hospitals (acute care and extended care); rehabilitation units (both "special" and "general"); chronic hospitals; nursing homes; and Homes for the Aged (bed care, special care, and normal care sections). For definitions of each level of care, see the body of the Report.

COMMUNITY

For the purpose of this report, "community" includes the following levels of care: lodging houses; special living facilities such as hostels, etc.; support services such as V.O.N., St. Elizabeth's Nurses, Public Health Nurses, Meals on Wheels, Homemakers, etc.; other services such as Day Therapy Centres, etc.; and home with no formalized services being provided.

CODING DEFINITIONS — in the order that the terms are used on the Data Sheet (see A.P.S. Data Sheet and Coding Forms in Appendix)

REFERRAL FORM NUMBER

— number of times the applicant has been referred to A.P.S. and the referral process initiated: i.e. contact sheet completed, forms mailed out for completion, or a partial or complete Referral Form.

TYPE OF SERVICE 4 categories —

1. *Referral — No Contact* — minimal information on a patient and have not formally received referral. Includes those who have applied at an extended care facility, without going through A.P.S. and have been refused admission (i.e. the facility informs us of the person's name but the person themselves or someone acting on their behalf has not called A.P.S.)
2. *Brief Service* — person has been formally referred to A.P.S., a contact sheet has been completed and perhaps the Referral Form has been mailed out for completion. No forms have, as yet, been returned. Case may still be active, or may be closed.
3. *Partial Assessment* — person has been formally referred to A.P.S., contact shet has been completed, and either the social-nursing (pages 1,2,3,6,7,8 of Referral Form) or the medical (pages 4 & 5) section has not, as yet, been completed. The case may still be active or may be closed.
4. *Complete Assessment* — person has been formally referred to A.P.S., contact sheet has been completed, and the complete Referral Form has been returned to A.P.S. office.

NUMBER OF DAYS IN PROCESS

— number of days *between* certain events in the referral and placement process, including weekends.

ADDITIONAL INFORMATION REQUIRED

— recorded only if both the social-nursing and the medical sections of the Referral Form have been returned, and further information was required from health professionals, family or patient to make a decision on the level of care required, or the facility or program best suited to the person's needs.

LEVEL OF CARE RECOMMENDED (see Health Care Facility code list in appendix, and definitions of each level in body of report)

— the level of care of the facility that was recommended as the *first placement step* (i.e. sometimes a series of placements are recommended: 1st to Chronic Hospital for physiotherapy, then to a Nursing Home or a Home for the Aged, depending on improvement. The first step, Chronic Hospital, would be recorded) in the *final recommendation* (i.e. after additional information is received, if applicable) for that particular referral.

LEVEL OF CARE OF ACTUAL PLACEMENT (see Health Care Facility code list in appendix, and definition of each level of care in the body of the report)

— the level of care of the facility that the patient was actually placed in.
— No placement was recorded (even if one did take place) if no recommendations were made, or the Referral Form was incomplete (Satisfaction was coded as Not Answered (99) in these cases, even if follow-up was completed).
— Placement was recorded as taking place the same day as the recommendations were made: when the patient stayed where he was; and when the patient refused our recommendations, and made plans of his/her own.
— If further information is obtained on the cases where our recommendation was refused and placement is known to have taken place without A.P.S. assistance, that facility was recorded as the actual placement.

SATISFACTION WITH ACTUAL PLACEMENT (see Satisfaction Code)

— Refers to A.P.S. satisfaction with a placement, taking into consideration the institutions, facilities and services as they presently stand. The judgment is based on a follow-up (by telephone usually) carried out one month after a person's placement. A.P.S. might conceivably consider a certain placement generally unsatisfactory, on the basis that the person's needs are not being met adequately according to our information, while the patient themselves may be quite happy with the placement.

BRAIN DAMAGE

— Questions 1 and 2 (Memory and Orientation and Ability to be Realistic in Judgment) under Psychological Functioning on page 4 of the A.P.S. Referral Form were grouped in such a way as to yield three categories of brain damage: no brain damage, impaired, severely impaired.

MOOD AND BEHAVIOR

— Question 3 (a) to (f) (Mood and Behavior, Mood, Participation, Cooperation) under Psychological Functioning on page 4 of the A.P.S. Referral Form were grouped in such a way as to give two categories regarding mood and behavior: no functional psychological impairment, functional psychological impairment.

ACTIVITIES OF DAILY LIVING

— Questions 3, 4 & 5 under Communication (Ability to be understood by others in own language, Ability to express self by words or gestures, and Ability to comprehend present life situation and future) and Questions 1 to 7 inclusive under Self-Maintenance (Ability to use toilet, to feed, to dress, to groom, to bathe, Bed care, and Ambulation) in the Functional Capacity section (pages 6 & 7) of the A.P.S. Referral Form were grouped in such a way as to give three categories regarding activities of daily living: no problems, impaired, severely impaired.

FAMILY PHYSICIAN

— The family physician, or the responsible physician was coded from a list drawn up from the *Canadian Medical Directory* representing physicians from Ancaster, Binbrook, Burlington, Caledonia, Dundas, Freelton, Grimsby, Hamilton, Smithville (West Lincoln), Stoney Creek, Waterdown, Winona. They were assigned numbers from 1 to 791 and additions were made from

various communities (some outside the Hamilton District Health Council region) numbering up to 881.

DIAGNOSIS

— Primary and Secondary: Subgroups from the *International Classification of Disease (Adapted)* were utilized. The order in which the physician listed the diagnoses was not necessarily used as an indicator of primary or secondary diagnosis. Primary diagnosis was the chief presenting complaint at the time of referral: e.g. a hip fracture brought the person into hospital where they were referred to A.P.S.

RESEARCH COMPONENT OF A.P.S.

A.P.S. has worked closely with the Department of Clinical Epidemiology and Biostatistics, Faculty of Medicine, McMaster University as part of a Regional Service Program. The following is a statement of the input of the A.P.S. staff in conjunction with the Regional Service Program in order to compile the "First Annual Report".

Research Question

Research is an integral component of the activities of the Assessment and Placement Service. A.P.S. serves people of any age who need long-term treatment, or special living facilities, and by working with family physicians and health teams assesses both medical and social problems in order to determine the level of care required. Placement is recommended in accordance with the assessment, and A.P.S. is thereby able to collect accurate information about what is still needed in treatment or care programs.

Personnel Involved

The Medical Director, Administrator, Information Coordinator and Data Analyst, Secretary and Steno-Clerk were the A.P.S. personnel involved in compiling the Annual Report. The Department of Clinical Epidemiology and Biostatistics of the Health Sciences Centre at McMaster University offered input from seven persons with different areas of expertise (not including two keypunchers).

Data Collection

The first step in the collection of data, was the development of an assessment form sensitive to a person's medical and social needs, and wishes regarding placement. (The assessment form is described in the body of the report, and a copy of the latest version can be obtained by contacting the A.P.S. office.) An abstracting coding form (i.e. A.P.S. Data Sheet — see appendix) was developed for the purpose of making some of the information contained in 1483 assessment forms more amenable to statistical analysis. It is expected that the next draft of the assessment form will be used as the coding form as well. The data was transcribed from the assessment form and various other office forms onto the A.P.S. Data Sheet. This involved two levels of coding: "low level coding", where the information is recorded on the assessment form in exactly the same format as on the data sheet: and "high level coding", where some interpretation of the information on the assessment form had to be made, such as in coding the primary and secondary diagnoses. Once the information was transcribed onto the data sheets, the data was key punched onto computer cards and verified. In order to enter the data on the computer, a code sheet was written, and both the code sheet and the data cards were "debugged" to ensure as few errors as possible.

Analysis of Data

The first step in the analysis of the data was a listing of the response distributions to all questions. Two-way table analysis was carried out to test certain hypotheses concerning the effectiveness of A.P.S., and to describe, with more precision, the population served by A.P.S. The tables generated more hypotheses and more two-way table analysis. For the purpose of the actual writing of the Annual Report, it was decided what were the most important tables to be included and these were then described in words in the body of the report.

Future Research

The information recorded in the first year of operation of A.P.S. provides useful comparative measures of the performance of A.P.S. and the various programs in the region for the second year of the operation of the service. We will continue to gather data to evaluate the effectivenss of A.P.S. and to identify what is still needed in treatment or care programs.

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